DOCUMENT RESUME

ED 463 398 CE 081 295

AUTHOR Phillips, Terry; Schostak, John; Tyler, Judith
TITLE Practice and Assessment in Nursing and Midwifery: Doing It for Real. Researching Professional Education Research Series Report.
INSTITUTION English National Board for Nursing, Midwifery and Health Visiting, London.
REPORT NO ENB-RR-16
ISBN ISBN-1-901697-59-2
PUB DATE 2000-00-00
NOTE 180p.; Includes "Practice and Assessment: An Evaluation of the Assessment of Practice at Diploma, Degree and Postgraduate Level in Pre- and Post-Registration Nursing and Midwifery Education. Research Highlights 43."
AVAILABLE FROM English National Board for Nursing, Midwifery and Health Visiting, Publications Department, Victory House, 170 Tottenham Court Road, London W1P OHA, England, United Kingdom. Tel: 0207-391-6314; e-mail: pubs@enb.org.uk.
PUB TYPE Reports - Evaluative (142)
EDRS PRICE EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Case Studies; *Clinical Teaching (Health Professions); Competence; Education Work Relationship; Educational Improvement; Educational Needs; Educational Practices; Educational Quality; Educational Research; Educational Trends; Employment Qualifications; Evaluation Criteria; Evaluation Methods; Evaluation Research; Foreign Countries; Higher Education; Job Skills; Literature Reviews; Models; Needs Assessment; Nurses; Nursing; *Nursing Education; Obstetrics; *Performance Based Assessment; Portfolio Assessment; Portfolios (Background Materials); Professional Education; *Program Design; Skill Development; State of the Art Reviews; *Student Evaluation; Systems Approach; Testing Programs; Theory Practice Relationship; Trend Analysis
IDENTIFIERS *England; *Midwives

ABSTRACT

The assessment of practice in nursing and midwifery education programs across England was examined to determine its validity, reliability, fairness, and effectiveness in maintaining and developing the quality of care. The research was conducted in two phases. Phase 1 was designed to identify theoretical and practical areas of concern that would frame the rest of the study. Phase 2 consisted of in-depth studies of workplaces as sites for structuring project opportunities to conceptualize the development of practice-driven curricular and assessment projects and case studies of the key relationships underpinning assessment/assessment in the workplace. A total of 518 interviews, 219 observations of practice, and several shorter observations of discrete elements of practice were conducted. A three-stage model for moving from a piecemeal quasi-structure to an integrated assessment infrastructure was outlined. The elements of the three stages were as follows: (1) networks and dialogue nodes serving as an infrastructure for trust; (2) collaborative structures for education, curriculum development, and assessment of practice in practice; and (3) development and monitoring structures supporting full-fledged assessment

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monitoring. Although assessment quality assurance practice and deployment of resources varied greatly across England, environments with the characteristics of the proposed assessment infrastructure were found. (Contains 11 figures and 95 references.) (MN)

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# RESEARCHING PROFESSIONAL EDUCATION

## Practice and Assessment in Nursing and Midwifery: doing it for real

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# RESEARCHING PROFESSIONAL EDUCATION

*A series from the English National Board for Nursing, Midwifery and Health Visiting*

# Practice and Assessment in Nursing and Midwifery: doing it for real

Terry Phillips
John Schostak
Judith Tyler

London, 2000

Published by
The English National Board for Nursing, Midwifery and Health Visiting,
Victory House, 170 Tottenham Court Road, London W1T 7HA
Telephone: 020 7388 3131
Fax: 020 7383 4031
E-mail: pubs@enb.org.uk
www site: http://www.enb.org.uk

© English National Board for Nursing, Midwifery and Health Visiting, 2000

ISBN 1 901697 59 2

This report has been prepared for publication by
Jill Rogers Associates, Cambridgeshire
Design by Sadler, Suffolk
Printed by Piggott Printers Limited, Cambridge

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## Acknowledgements

The project team would like to thank the very many dedicated, hard-working and hard-pressed nurses midwives, students and educators who generously found time to talk to us and willingly allowed us to be alongside them as they did their caring, educating and assessing. Although we have written this account they are its true authors. We would also like to thank colleagues at University of East Anglia (UEA), members of the project Steering Group and Dr Sonia Crow for moral support, stimulating discussions and wise advice.

## The Steering Group

Professor Colin Biott (Chair), Professor of Professional Education and Development, University of Northumbria at Newcastle

Dr Sonia Crow, Assistant Director for Educational Policy (R&D), English National Board for Nursing, Midwifery and Health Visiting

Dr Kate Gerrish, Reader in Nursing Development Practice, Sheffield Hallam University

Richard Hogston, Section Head/Nursing Officer, Education Policy, NHS Executive, Leeds

John Leung, Education Officer, District Nursing, English National Board for Nursing, Midwifery and Health Visiting

Professor Lesley Page, Professor of Midwifery, Thames Valley University

Azad Ramkoleea, Education Officer, Mental Health, English National Board for Nursing, Midwifery and Health Visiting

Dr Harry Torrance, Professor of Education, University of Sussex

## The Authors

**Terry Phillips** is a Senior Lecturer in Applied Research in the Centre for Applied Research in Education, University of East Anglia (UEA). He is co-director of the post-disciplinary EdD programme at UEA. He has directed or participated in research projects and evaluations of teaching and learning, nursing and midwifery, interprofessional team care and higher education. He has published widely on education and dialogue in institutions, language and learning in schools and communication for understanding in education for the professions. Key research themes include: the identification and critical examination of texts, discourses and practices in educational and workplace settings, the construction of knowledge across 'boundaries', the creation of knowledge through 'doing' in 'difficult' contexts, creativity and learning, collaborative research with marginalised groups, and the development of research methodologies.

**John Schostak** is Professor and Director of the Centre for Applied Research in Education, University of East Anglia. He has been involved in 40 funded research projects across a range of areas such as schooling, health, policing and business environments. Key research themes include: research and evaluation of institutional change, professional development, strategies for inclusion, the development of learning environments, the impact of information technology on the personal, social, cultural and political life of people, youth cultures and the development of qualitative research methodologies. He has published in each of these areas. For example: *Dirty Marks: The Education of Self, Media and Popular Culture*, Pluto Press (1993), *Framing the project. A Dialogic Approach to the Design and Conduct of Qualitative Research in Education*, Open University Press, (in press).

**Judith Tyler** has enjoyed a long and varied career in the National Health Service as a nurse, midwife and health visitor followed by experience as a youth worker and adult education lecturer with the local education authority and a social services foster carer. For the past 14 years, she has been engaged in various aspects of nurse education, and is currently a senior lecturer with the University of East Anglia School of Nursing and Midwifery Research Unit.

She has been awarded several research scholarships and has a significant record of published work. Her clinical and research interests include: psychological studies of occupational and environmental stress, ageing and the ethics of elderly care, HIV/AIDS and a number of educational studies in the assessment of professional practice.

# *Foreword*

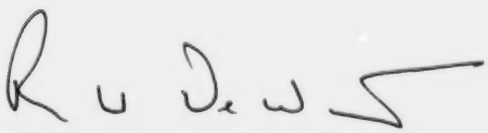
The English National Board for Nursing, Midwifery and Health Visiting is delighted to publish this report as the sixteenth in its successful series: *Researching Professional Education.*

The Board launched this series with the aim of making widely available the results and implications of research commissioned by the Board. The series enables key stakeholders: policy makers, managers, practitioners, researchers and educators to have access to relevant and sound research from which to plan educational developments.

The quality of assessment of practice varies widely. *Practice and Assessment in Nursing and Midwifery: doing it for real* investigates how practice is assessed in clinical environments. It looks at the interaction between what assessors 'do', the way organisations are structured and how resources are distributed. The researchers observed learners and assessors at work to build up a set of case studies of the working day. At the same time they collected evidence of the reality of assessment in these circumstances.

The research shows that the quality of assessment and learning require the support of appropriate institutional and national infrastructures.

The conclusions are of relevance to a wide multiprofessional audience in health care and education.



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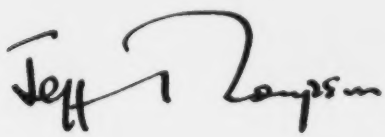

**Professor Jeff Thompson**

Chair, Research and Development Committee, English National Board for Nursing, Midwifery and Health Visiting

London, 2000

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## 1.1 Introduction

This report provides a detailed account of a research project commissioned by the English National Board for Nursing, Midwifery and Health Visiting (the Board) to investigate the assessment of practice in pre- and post-registration nursing and midwifery education and evaluates its validity, reliability, trustworthiness, and fairness as well as its effectiveness in maintaining and developing the quality of care. It considers the implications of the findings for professional awards at diploma, degree and post-graduate level. The research is grounded in evidence from lived experience of both practice and assessment.

Evidence is provided in the form of extracted comments from interviews, but also uses longer sections from selected interviews to show how interviewees map the issues as they perceived them and how these issues are always related to work as much as education/assessment. However, since this is an evaluation of what happens when real people working in real contexts are 'doing' practice and 'being' assessors, assessees, programme co-ordinators, carers, a major part of the evidence comes directly from what was observed in the clinical workplace. It is presented in the form of extracts from observational field-notes, mini-vignettes constructed from these to place reported experiences in context, and longer vignettes describing contextual detail and moment-by-moment activity in greater depth to enable the reader to compare their unpicking of the evidence with that of the researchers. The vignettes within the report may be used in the teaching of practice assessment skills.

Previous research has identified similar problems to those identified here. However, this report identifies a range of issues pertaining specifically to:

- the assessment of practice in the practice environment
- assessment as an essential correlate of education and work.

The current evidence highlights the interconnectedness of work, curriculum and assessment and reveals the dilemmas and opportunities faced by all concerned as they work out ways of living with the contentions between these three.

Previous research has described the problems of assessing theory and practice together and of doing assessment as an additional chore on top of the work of caring, but has failed to explain why the problems occur. In the research reported here, it is apparent that the difficulties are not normally a consequence of negligent or inefficient action by practitioner-assessors or lecturer-practitioners, but of a failure at individual, institutional and policy levels to recognise the nature of the relationship between assessment of practice and work, workplace learning, situated understanding and practical theory. To understand these it is necessary to see practice and assessment in the context of the work environment, which is itself within an occupational, professional, cultural and economic context. This report, therefore, includes extensive theorisation about these issues.

The theory is developed directly from the evidence of this and previous evaluations. It is presented in a way that is intended to allow the reader to make the journey in much the same way as the researchers did. For example, theoretical memos made during visits and developed over time are included, and the theorising is written alongside the evidence rather than in its own chapter; the intention here is to represent research in all its complexity and to retain the quality of the lived reality.

The broad theme of the project is the public's need for confidence in the professional knowledge, decision-making powers and practical skills of those who take care of them. The practice-based education of nurses and midwives at every level is central to this aim. The project

provides an evaluation of the assessment of practice appropriate to each level. Following *The ACE Report* (Bedford et al., 1994a), the Board introduced a section on Assessment in its Regulations and Guidelines for Approval and Validation of educational programmes. Since December 1997, institutions approved to offer pre- and post-registration programmes must be able to demonstrate parity and equity between theory and practice in curricular assessment strategies.

This provides the specific focus of the Board's concern as expressed in the invitation to bid that *'it is crucial to analyse and evaluate the ways in which assessment of practice discriminates between professional knowledge and competence at the appropriate academic level'* without ignoring other contextual factors *'such as the multiprofessional/multicultural nature of health care'*.

This deceptively straightforward focus soon deconstructs when confronted with the murky complexities of real-life practice. This report aims to describe how the researchers approached the task and to represent key aspects of the diversity of experience as well as open discussions on key issues that will enable the professions to understand the implications for designing approaches to assessment that address the realities of practice and provide a vision for implementing change. The research was carried out in two phases.

### 1.1.1 Phase 1

**Stage 1** ***(April-August 1997)***

- Negotiate access.
- Establish principles of practice.
- Carry out telephone and questionnaire survey.
- Carry out one-day 'survey' visits in fullest possible range of sites.
- Identify characteristics of 'successful' assessment practice.
- Select sites for Phase 1: Stage 2, taking account of criteria identified through survey, plus criteria of geographical location, level of course, part of the register represented and HEI/practice location history/culture.

**Stage 2** ***(September 1997-May 1998)***

- Make three-day intensive ethnography visits to selected educational institutions and partner primary, secondary and community sites identified in Stage 1.
- Observe and interview to identify 'operational definitions' of assessment practice, structures and processes in the full range of clinical environments.
- Collect data on resources, staffing, clinical specialisms, support structures, higher education culture(s) and clinical practice culture(s).
- Identify other variables.

At the end of Phase 1, the evaluation had identified some key areas of concern. There were two dimensions to this concern:

*A theoretical dimension* – a deeper understanding of processes at work was required before adequate theories, explanations, interpretations or models could be explored

*A practical dilemmas dimension* – structural and process contradictions, conflicts, resource insufficiencies and other practical problems had to be explored in order to understand how opportunities to bring about resolutions might be structured.

These were the focus for Phase 2, which adopted the following strategy:

- In-depth studies of the workplace as a site for structuring educational/learning/innovative project opportunities in order to conceptualise the development of practice driven curricular and assessment processes.

- Educational case studies of the key relationships underpinning education/assessment in the workplace: practitioner-assessors, clinicians with other forms of teaching and assessment roles, academic staff acting as liaison tutors, students (focused on their role as assessee). As well as interviewing and document collection, data gathering would include 'shadowing' key role-holders for a period of time.

### 1.1.2 Phase 2

Stage 1 *(June 1998-Feb 1999)*

- Carry out further intensive fieldwork to study sites selected in Phase 1, Stage 2, focusing through branches, specialisms and levels, and through 'issues'.
- Explore issues of validity and reliability.
- Construct framework for educational case studies and vignettes.

Stage 2 *(March-November 1999)*

- Conduct in-depth educational case studies of situated practice assessment through longer-term contact with the subjects of the research.
- Analyse data from face-to-face interviews, telephone interviews and site visits.
- Develop condensed versions of the educational case studies by constructing vignettes of practice, to ensure the reality of experience is presented in an accessible and contextualised form.
- Further address the issue of coverage by checking the findings from the in-depth educational case studies with the fullest possible range of institutions, programmes of education and practice areas.

### 1.1.3 Key aims of the project

The project proposal identified two key aims, each with a number of contingent questions, issues and objectives drawn from the invitation to bid:

- to evaluate the effectiveness/outcomes of the assessment of the professional knowledge and competence of students at different academic levels within the practice area
- to evaluate the validity and reliability of the clinical assessment through which judgements about effectiveness/outcomes are made.

To realise the first key aim, it was argued that evaluation should focus on the processes and principles employed to accomplish the integration of theory and practice at various levels of practice-based education, and on the development in practice outcomes as programme levels become more advanced.

The second aim would entail a study of variation and stability in the assessment processes used in clinical environments, an analysis of the validity of assessment, and a consideration of programmes to prepare clinical practice assessors. It would also require an audit of assessment quality assurance structures. The questions to be asked in relation to these aims were argued to include:

- Do assessment processes and practices provide adequate and appropriate evidence, and if so what is its nature?
- Are judgements on the basis of this evidence supportable?
- Does assessment take proper account of the contexts of care, including the differing cultural assumptions, beliefs and needs of a multi-cultural community?
- Does assessment take proper account of differences in practice context, including the differing demands of clinical branches and specialisms?

### 1.1.4 Study sites

Coverage was achieved through survey (visits and interviews) involving a wide range of institutions providing higher education or clinical practice. Selection factors included:

- geographical location
- range of programmes offered
- level of programmes offered
- nature of clinical specialism
- history and context of the relationship between the educational institutions and their clinical partners.

Observations in practice and fieldwork interviews were in the following geographical regions: North East, East Anglia, South East, South and South Coast, South West, West, North West, the Midlands, London and the Home Counties. A full range of specialties representing a spectrum of adult, children's, mental health and learning disabilities nursing, midwifery and maternity care (with institutional and community provision in each of these areas) was visited. Sites were selected to include programmes of education at diploma, degree and Masters level.

A total of 518 interviews, 219 observations of practice (half days or entire duty shifts) plus several shorter observations of discreet elements of practice, e.g. formal assessment interviews, were conducted. Examples and quotations used have been carefully selected from the vast amount of data amassed, to capture one of the following:

- a type of incident or comment which occurred consistently throughout the project
- an incident or experience which occurred less frequently but represented an extreme experience with marked implications for the assessment of practice in that environment which could be extrapolated to less dramatic examples occurring more generally.

The comments cited:

- were typical of many which were recorded but which had sufficient impact and originality of expression to convey a real sense of the dynamism within the situation and the vehemence and passion with which participants responded to issues which clearly had immense significance for them
- provided useful sub-headings to include in the project text, to enhance its accessibility, endorse its relevance and confirm its impact.

Assessment is often seen as an add-on to the processes of education and training, rather than as something permeating the process. In this report the focus is on education as a the process of 'drawing out' opportunities for knowledge, improved judgement, personal development, and skilled, critical and sensitive action.

## 1.2 Educative assessment: the theoretical framework of the research

Assessment is portrayed as an integral part of this process. This chapter illustrates how educative assessment may be seen as a dynamic, mutually-reinforcing process of reflection, exploration of alternatives, critique and evaluative action. It is premised on the understanding that to be valid, assessment must be tailored to curriculum needs that are relevant to improving judgement, decision-making and action in the workplace context.

### 1.2.1 The practice curriculum

A curriculum does not exist by itself as a tree might exist. It is socially constructed for some purpose (Elliott, 1997; Schostak, 1988; Goodson, 1984; Goodson and Ball, 1994) – it is

always *of* something *for* someone. Traditionally curricula have been thought of as the process of transmitting bodies of knowledge, skills, practices, attitudes and values; they define how an individual is inducted into professional territories. More recently, a large body of literature has highlighted the phenomenon of the hidden curriculum. This may be interpreted as both intended and unintended learning experiences arising while pursuing a particular curriculum which are not openly stated as a part of that curriculum. For example, a primary school curriculum may be explicitly about teaching maths but the teaching processes may involve the hidden curriculum of learning to submit to authority, to do trite tasks without complaint and to handle boredom (Jackson, 1968). By attending closely to actual practice and the interpretation of lived experience, the hidden curriculum points towards an alternative way of defining the curriculum. It is not the curriculum of 'following well trod paths' but of 'discovery where the paths are yet to be created'. Such paths are only discovered by looking back, or reflecting upon where one has been in order to make sense of the journey for present and future profit and pleasure (Schostak, 1983; 1988; Phillips et al., 1996). This conception of the curriculum, it is argued here, is most appropriate for practice-based learning and assessment where the role of assessment is to:

- map the curricular experience
- evaluate the extent to which it has been explored and adequately developed
- make a judgement concerning the quality of learning, understanding, judgement, performance and ability to take justifiable action informed by evidence.

The assessment of a practice curriculum is therefore not a separate activity, but is integral to the educational process by which individuals become professionals and subsequently develop their professionality. Since a curriculum is always of *something* for *someone*, practice-based curriculum design needs to be appropriate to:

- work practice and its circumstances
- changing work practices and circumstances
- the process of dynamic decision making.

This defines the 'something' towards which educational acts are directed. The *someone* includes:

- the individual (whether assessee or teacher/mentor/assessor)
- the 'you' as a specific source of otherness, or difference which must be either excluded or incorporated as an 'us' or 'we'
- the 'us' or 'we' (two or more seen to be acting as a group) whether these are seen as:
  - productive of 'consensus'
  - agreements to differ and to maintain debate
  - for creative alternatives
- the 'authorities' or 'them' (the 'personalised' source defining what is to be taught/learnt).

The curriculum *act* itself:

- can transmit set bodies of knowledge, skill, practice, values and attitudes, which can be either manifest or hidden
- can be historical (produced through acts of reflection upon the 'paths' travelled) for organising present and future acts.

The combination of these three dimensions (the subject, the object and the act) produces different ways of designing a curriculum.

This report does not aim to review the massive curriculum development literature. Rather it will provide a particular view of kinds of curriculum from the standpoint of the above

analysis and the intention to develop curricular and assessment approaches appropriate to professional needs and the realities of practice. There are many ways of categorising types of curriculum. The following provide a way of thinking about curricula from the point of view of 'agency', the motive force, the initiating 'centre' for the process.

## 1.3 Practice curricula

### 1.3.1 Transmissive curricula

Transmissive curricula render the individual passive and the 'authority' active in producing what may be termed 'master curricula' after the post-modernist terminology which has critiqued master narratives (Lyotard, 1984) and the master discourses of the psychoanalyst (Lacan, 1977). The teacher is the vehicle by which the master curriculum is conveyed to the assessee who can only show mastery by reproducing that which is taught. Assessment is thus a relatively simple matter of matching what has been reproduced with what has been 'transmitted'. This kind of approach may be considered critical in tests of accuracy, and hence of safety, in the application of techniques and treatments.

### 1.3.2 Self-reflective curricula

Where the individual is the prime source of authentication and verification the curriculum is in danger of becoming increasingly private and indeed eccentric since external sources (the other) recede in importance as against individual or personal interpretation. There is a danger of solipsism; while transmissive curricula overvalue the external source of transmissive authority, self-reflective curricula overvalue the inner source of experience and interpretation, referring all to a personal system of analysis, association and categorisation. Assessment depends entirely upon the individual's subjective valuations. There is no external critique of the formation of judgement if all is sealed into a private world.

The use of personal 'reflective' diaries has often had this effect of privatisation. Writers use such diaries, in a sense, to purge themselves of various emotional reactions to work experiences.

### 1.3.3 Intersubjective curricula

The intersubjective curriculum is founded upon the relationship between multiple subjectivities. It recognises an 'I', a 'you', a 'we/us' as well as a 'them'. Different kinds of intersubjective curricula will emerge depending upon the relative weight accorded the different kinds of subject (I, you, us/we, them). All share a concern for consensus, even if it is of the form: 'I want you to agree with me and will not rest until you do so'. Assessment involves a process of negotiation towards a consensus statement as between fellow professionals. It is fundamental to the processes of triangulation that seek to reduce the bias involved in assessments of the 'objective' worth or status of whatever is observed. It can be argued that the assessee's judgement is progressively formed by exploring what is common and what is different amongst a range of professional views and experiences. However, while triangulation of views may reduce the bias of a given individual it does not necessarily guarantee accuracy, validity or truth. Millions of people from many expert groups believed the world was flat during the Middle Ages; they were proven incorrect by evidence generated by methods inconceivable at that time and in that particular context. Triangulations of views may well prove to be more a pressure to conformity rather than a move towards valid explanations and understandings. This is why triangulation must be accompanied by a critical attitude that is open to alternatives.

The careful use of triangulation may be important and necessary to the development of evidence, but it does not *necessarily* include the process of dialogue as described below. While an intersubjective approach is necessary to open private judgements to the views of others, this may have a pacifying effect on the individual as agent in the sense that it promotes a consensus view of what counts as accuracy and coverage in the development of professional competence. (This is a danger of the delphi technique in trawling for expert opinion that progressively

excludes minority views in favour of the most generalisable opinions.) Worse, the search for consensus may promote compromise, complacency and the 'quiet life', where boats are never rocked.

### 1.3.4 Dialogic curricula

Dialogic curricula recognise multiple kinds and levels of subjectivity and intersubjectivity and thus do not ground truth, authenticity, validity and so on upon one privileged point of view, method, process or framework for knowing, feeling and doing. Dialogue not only recognises but also values diversity (otherwise it would reduce to being intersubjective agreement which in turn would be reduced to monologue) and does not seek consensus for the sake of it. Dialogic approaches are appropriate for exploring and seeking to inform judgement under conditions of indeterminacy and uncertainty. Dialogically-framed assessment preserves the diversity of values within contexts of action and explication. It takes the form: *'if "x" is the context, "y" the circumstances and "z" the vision of values and ways of being, then it can be argued that "a" is appropriate; but this must be set against alternative definitions and ways of seeing as follows …; the criteria for forming a rationale for action within this given context and these given circumstances then rests upon these kinds of considerations …'*. Although proposed in both *The ACE Report* (Bedford et al., 1994) and *The TYDE Report* (Phillips et al., 1996), dialogic curricula appear to be little in evidence. Some insights as to how they may be developed are discussed in other parts of this report.

## 1.4 Assessment voices

It is no great surprise to find that the range of assessment practices is far more limited than imagination and philosophies might allow. Opportunity structures to sustain difference and excellence in practice are severely constrained at the level of resources. Nevertheless, even if only at an embryonic level a range of different kinds of practice can be identified in accounts of staff and assessees.

### 1.4.1 The voice of mastery

The assessment voice of mastery seeks coverage and competence in the performance of routines and execution of skilled tasks. Learning occurs by doing what is required by those recognised as having attained mastery. Such a view is implicit in approaches as apparently different as Bloom's (1954; 1956) taxonomy and Benner's (1984) model of novice and expert. One seems to emphasise tasks and behavioural skills while the other emphasises the holistic and dynamic nature of processes. This is an important shift, albeit one that does not deconstruct the notion of mastery implicit in the concept of the expert. When reflecting upon changes in nursing during the last 20 years, interviewees typically appeal to the shift as follows:

> **Assessor:** *'… the biggest change when I was training was from task allocation to primary nursing.'*
>
> **Student:** *'Mm mm.'*
>
> **A:** *'And my general nurse training was very much "you're the student you're in the sluice, you do the denture round you do the …" '*
>
> **S:** *'Right.'*
>
> **A:** *'… temperature round and then that was all turned on its head slowly over a period of time and again depending on the sister whether they were for or against this new team nursing system. Whether that worked in some wards or not then you would get allocated a group of patients and you would do everything for that group of patients and I seem to remember that the transition period was that you'd have a group of patients, but if you finished your group of patients first you would get asked to do the temperature round for the ward.'*

S: *'Right.'*

A: *'You know so they would fall back into "well we'll just get that done now while you've done that".'*

S: *'Mm.'*

A: *'… and if you were seen sat talking to a patient "have you got nothing to do nurse?"'*

(On-the-ward exchange between second-year nursing degree student and her assessor)

This is 'mastery' in the traditional sense. The qualified nurse knows what should be done and instructs the assessee what to do next. It is the mastery of routine and practical steps. In relation to the voice of mastery, the assessee can offer nothing in their own voice. The power is always with the other as master, the source of authority who is the final judge as to right or wrong. The task of the assessee is to internalise what is right until she or he becomes a master; the focus of mastery is on coverage and accuracy. Organisations often develop surveillance and control systems to check on coverage and accuracy. Typically these result in long, cumbersome checklists, the validity of which are questionable. Relationships of mastery are typically 'nested' both within a given profession and between professions. In particular, there is the traditional view of the relationship between medical care and nursing care as in the following interview with a consultant talking about the timing of business and educational rounds in training junior doctors (Schostak and Schostak, 2000):

**Interviewer:** *'Now what it sounds like there is that there is a lack of communication between the different um groups organising care for that, that individual. In, in the sense that perhaps the nursing side have their agendas and so forth, and you have your agendas, and not necessarily do they come together in timing.'*

**Consultant:** *'Exactly right, exactly right. More than that, the, the actual timing for the interface is now so limited because of, of the work either side. I might go up at eight o'clock, which is a terrible time for the nurses, who have just had change-over going round, some patients are at breakfast. But I can't do it any other time … I've got to be in clinic at nine, or the ante-natal clinic or in theatre, theatre at half-past eight. So unless you do your sessions at those difficult times, um, sessional time during the day for ward rounds with a designated time eleven o'clock in the morning time, er, then the mid, then the nurses, they're not, er, dare I say it, I think that the numbers of the nurses on the ward do not allow that sort of laxity, they could, they could do that because there's always something going on, there's always someone to be nursed, rather than to walk round, er, almost talking about care, which is a sad reflection, I think. I've seen that deteriorate in my time of training and into a consultancy.*

*'There is a talk towards shared managed care. I heard it for the first time yesterday, which means that the professional bodies write in the same notes, and we all have the same, as we should, have the same outlook to the patient with, with their being a professional nursing service, the docs, and everything going to one direction. Um, over the last few years, with the way nursing levels and practice has been going, even though that might have been one of their educational aims or one of their views in terms of quality and delivery of care, we have gone further apart … It hasn't happened because, as you quite rightly say, the ability to get together on those sort of issues is not, some of the old style nursing sisters, of which we are lucky to have some of the best, have maintained those skills*

*despite the changes. I went onto a ward, yesterday, and I saw a patient without the nursing cover who was looking after that patient. And Sister was very cross, not with me, because I'd been there, but she was cross at the system that she had governed that she would be there, because she appreciates, not, it's, it's for the wellbeing of the patient overall, but anything that the consultant or the team need to say about the management of that patient may be missed or may not be accurately reflected, so she was very cross with that system and they are worth their weight in gold.'* (Interview with consultant)

In this view, the nurse was there to pave the way for the consultant, to provide information when and where he needed it. Medical care here is in the role of master.

### 1.4.2 Self-reflective curricula

In this perspective the location of power changes from that of the other as master to the self as the centre of reflection. Diaries have traditionally been used to record private thoughts; in contemporary professional development, they have become the *sine qua non* of reflective practice. The keeping of a diary is recommended in textbooks on action research and other forms of research-based practice. Indeed, action research encourages the agency of the professional. How and to what extent this approach may be integrated into building practice curricula is discussed in the ensuing text.

Pre- and post-registration programmes of education in nursing and midwifery now routinely employ the diary. It is frequently a private resource which can be selectively used for essays and other course demands:

**Student:** *'I keep a diary and every time I'm at work I write up what happened. It's good at jogging your memory of things you have done and how you feel it has gone … That's for me, but when I come to write critical incidents I can use that to help me write.'*

**Interviewer:** *'How does all the thinking that you've done in your reflective diary get displayed to others?'*

**S:** *'A couple of months ago I sat down and thought about what skills I needed. I'm quite used to handling babies, but I have no midwifery experience, so I did a learning agreement with my SPT and agreed that by the end of semester one I would have spent some time with the community midwife and also had a few sessions in the child health clinic, mostly babies, also observing her when she does a new birth visit and her observing me when I do one.'*

**I:** *'Is there anywhere where that conversation is displayed?'*

**S:** *'No, only from my reflections as to how the whole process has gone. You can do critical reading and critique them and use bits of the reflective diary. It's left up to you to decide how to fulfil the outcomes.'* (Student)

Some find the keeping of a reflective diary a tedious exercise which, after a period of initial enthusiasm, slips from consciousness. Others find that due to competing priorities the diary becomes just another pressure. Others find it a way of handling their anxieties. Since the reflective diary is for most programmes a matter for the assessee alone, its usefulness as a critical resource that may contribute to professional development is largely unexplored. Used differently, however, it could be integral to the construction of evidence bases in terms of:

- curriculum mapping
- informing the development of the assessee's judgement

- exploring issues of validity, accuracy, coverage, bias, the drawing out of assumptions and consequences and so on.

These issues are explored in detail in Chapter 7.

### 1.4.3 Intersubjective curricula : mutual voices

Mutuality involves engaging the voice of the assessee in the construction of daily work activity with that of the assessors, mentors and other colleagues:

> *'I encourage mentors to sit down with students to identify learning needs regardless of the CAPs document. It gives students the responsibility for their learning.'* (Nurse education tutor)

This could be the first step in generating a critical triangulation of perspectives between mentor, colleagues and assessee. Within this triangular dialogue one could pose the question 'what counts as learning needs?' from the perspectives 'what counts as the data that could evidence the presence of such needs?' and 'what counts as the activities and experiences that could enhance learning in such a way that those needs are fulfilled?'. Its purpose would then be to generate an educational course of action resulting in a personalised curriculum focused on the workplace as a source of opportunities to learn. However, when the unit is busy: *'The student's needs aren't even secondary, they become insignificant … It's not a case of "Come with me you'll enjoy this" and the poor student is left on the fringe not knowing what's happening, why it's happening or if what they're seeing is good practice, brutality or neglect. Then you have to remember that there will be an aftermath and you have to remember to sit with the student and allow them to verbalise all their anxieties that that situation has provoked with them.'*

Working conditions may thus mean that the assessee is excluded. If the assessee has been well prepared in terms of how to develop a workplace-based curriculum open to assessment through dialogue, this 'busyness' can provide curricular themes to engage critical thinking and the formation of judgement, skills, competency and justifiable action in relation to working practices, resourcing and the aims of care. If not:

> *'It's the first impression … that initial response has created an impression and it takes an awful lot of shifting … You can explain what the student is likely to experience but you can't legislate for what will happen … When it happens it's chaotic.'* (Nurse education tutor)

Unprepared, assessees cobble together explanations and understandings as best they can, or they learn to 'play the game', hide their feelings and look tough:

> *'Sometimes it's hard to find out what students think. One student said she was OK after a violent incident, but told her mentor she was upset about the brutality she had witnessed. He spoke to her but she told him she was OK.'* (Manager, adult mental health)

Witnessing brutality, handling it, being 'OK' about it – what sort of curriculum and assessment of learning is this? How can such experiences be brought into the realm of critical reflection, the public domain where feelings can be acknowledged, support provided and courses of action thought about and assessed? The diary itself may be used as a way of bringing the assessee's experiences into the intersubjective sphere. However, of what educational use is it if they only create added pressures for the assessee? Indeed the more public the diary becomes, the more it may function as a surveillance mechanism which invades privacy and generates problems of confidentiality:

> *'I actually have enjoyed my reflective diary. The only problem being, as it's something that you have to do. I have to fit it in with everything else. It becomes a chore. But I try not to let that happen because I have learned so much. From the reflective side. I have problems now about confidentiality I must admit. You know, because we're writing this down and your*

*reflective diary is part of your assessment, although it's not marked, and the tutors read it, we discuss it in class. Now, okay, I would say that, okay, you know that you can talk about a patient and not even you'd know her name, but because the community's or, let me say, like there are two or three nurses on our course, that have looked after these patients on the ward and these patients are long-term, chronic illness, they've seen them time and time again. I would only have to chat about some instance and they'd know.'*
(Post-registration degree student, Child branch)

The surveillance potential of diaries was recognised by this assessee *'So that you really have to watch your back'*. Such potential may also be used as a mechanism for quality assurance, or even in its more limited sense, quality control:

*'We've had long discussions about what a learning diary ought to be. Its purpose was to make the assessment process more transparent. We use it from a quality assurance point of view rather than for any notions about reflective learning. The emphasis is on underpinning knowledge, assessment issues and the processes of assessment. Expect to see some correlation between what is written in the learning diary and the decision the assessor makes. Often assessors will write down the sorts of questions they've asked. I will look at those questions, go back to the learning diary and see whether they are reflected in that, then go back to the student's evidence log of their practice to see whether they all interrelate, from a quality point of view.'* (Telephone interview, Assessment co-ordinator)

The issue here is how one distinguishes quality assurance issues from reflective practice issues, assessment issues and curriculum issues. The interview evidence suggests that there is a wide range of practice, from the diary being the private domain and concern of the assessee with little overt inclusion in quality or curriculum practice, to a surrogate for assessee surveillance and quality control.

Broadly, the assessee's learning experiences are treated as separate from and subordinate to daily work within a clinical area (see Chapters 2 and 6). As such, reflective practice has few intersubjective mechanisms with which to connect. After an interview with a ward manager the following theoretical memo was written by the research team:

*'The ward manager talked about the need to carry a considerable load of daily information in the head. Due to pressures on staff there was not time to write down information as they went along so had to remember it. This information then had to be transmitted to the next shift, or to other professionals as and when they were met. There seemed to be here a kind of oral history through which the knowledge required for decision making was carried. To what extent are assessees actually inducted into this kind of oral history of the knowledge required to be a competent and valued member of the team?'* (Theoretical memo 1)

*'There seems to be a link with the diary as a vehicle for the development and textual codification of this kind of oral-based knowing and knowledge. However it is clearly a missed opportunity. The diary, as currently used in this particular institution appears to be a waste of time. There are no prior guidelines for its use. Nor is the learning contract of much use. It is not providing an occasion for discussion of issues, and there is no real definition of 'excellent'. Assessees therefore do not know how these are concretely used as ways of judging upon their action. Again, there is no real codification of 'oral judgements' of assessees, which then get codified on a document which is essential to them as something that a future employer will see.'* (Theoretical memo 2)

In this report, a theoretical memo is a note made by the researcher as part of a process towards an ultimate understanding of his or her observations and experiences when conducting fieldwork, or engaging with the material generated. Initially descriptive, it may convey the gist of what an interviewer said or what was observed (as it does here) but more usually it is used to capture a highlight in the discussion; when a topic is raised, a new issue or a different way of looking at things emerges and can then be 'unpicked' and scrutinised for its meaning and relevance, both intrinsically and in relation to the wider aspect of the enquiry. It is a signpost in the researcher's questioning, indicating alternative routes to explore: a necessary stage in the development of the questioning process. It has been likened to an 'Aha' moment when a sudden shaft of light provides clarity within the surrounding complexity of the research issue. Theoretical memos capture elusive thoughts and transitory moments of connection and provide foci for an imaginative construction of the research reality and for reflection upon it. They can be shared between fellow researchers and debated by them and with research participants and interested peers. Used in this way, they are more than the early stages of analysis or a necessary prelude to writing, they are part of the research dynamic.

Nevertheless, there is an intersubjectively-defined landscape which all the professional actors perceive and are capable of mapping out and providing clues for the development of an integrated approach to practice curricula and their appropriate assessment. The theoretical memo continued as follows:

> *'There is a link also with [lecturer's] interview – he employed the term "recognition" – which may have a meaning similar to the ward manager's notion of "intuition". Both were concerned about being aware of the circumstances relating to a given individual in relation to an overall care plan and a particular context. It is not enough that a given student competently does x, y and z. It is how theses elements connect – perhaps this is like the notion of a "grammar" which provides rules of selection and combination. If a student can only do x, y and z (rather like [another lecturer's] distinction), i.e., can only do tasks, then it could be argued that other kinds of staff could be trained to do given tasks. If nursing is to be more than the sum of its tasks then there has to be some way of assessing or perhaps accessing this in a way that makes the case.'* (Theoretical memo 3)

These themes were later picked up in a theoretical memo written during a fieldwork visit to another institution:

> *'[Lecturer] also talked about what he called the practice curriculum where the assessee should drive the curriculum design in relation to the opportunities available in a given practice location. Their new assessment document will have a list of core elements which the assessee must be able to do. However, there is also this more open side. When pressed it was clear that the design side would not be open to comparison between assessees – since some assessees would be better at design than others and could thus be assessed on that – however, it would be possible to do this. It would seem therefore that assessment is essentially outcomes driven rather than design driven. The design side opens the possibility of assessing students according to their ability to map the issues problems relating to a given area and design an appropriate learning and research strategy in the development of their own curriculum. What this would "measure" would be the extent to which they would be able to formulate strategies to cope with any new area. It could be an indicator of not merely problem solving but problem recognition, formulation, analysis, exploration and resolution. This in turn may well lead onto the lecturer's notion of driving decisions through knowledge authority rather than hierarchical authority.'*
> (Theoretical memo 3)

Although only speculation when first written, it indicated directions for later stages in the research which are developed in the same memo:

> *'There appear to be two sides worth theorising: (1) the assessee's limitations; (2) the opportunity structure for learning that the practice placement offers. Both these place the emphasis upon the design side of the practice curriculum. In terms of the trust representative, he further emphasised two more dimensions: (1) the "doing" side and (2) the "interpretation" side. In this analysis he considered that you can get almost anyone to do the tasks, what you can't necessarily get is the interpretation, the associated judgements of a given action. It is, he considered, not enough to observe a nurse doing something; you need to know how they are interpreting their actions. Again, this seems to emphasise the design side of the curriculum rather than the execution of a series of observable actions.'* (Theoretical memo 5)

How a curriculum is to be conceived is crucial for designing assessment strategies: one cannot be studied without the other. Furthermore, the curriculum design takes priority over assessment. Curriculum design-led assessment addresses a more complex set of learning issues than does assessment-led curriculum design and pedagogy. Where interpretation takes precedence over imitative 'doing', a realistic account of multiple viewpoints needs to be addressed in order to explore the range of interpretations that may be given to observable tasks. In turn this raises the issue of difference: how may difference of opinion and of interpretation be handled? Although a degree of consensus may be a prerequisite to co-operation, collaboration and planning, if all must be reduced to consensus, this either reinforces conformity over creativity, or excludes the different as 'mad', 'bad' and 'sad'. The consequences of these latter possibilities are that change and development may be impeded, creativity thwarted and important needs and interests left unaddressed.

### 1.4.4 Dialogic curricula

Dialogue, albeit presupposing some intersubjective basis, does not presuppose consensus as a necessary starting point or indeed, as a necessary end point:

> *'The traditionally trained nurses feel threatened, for all that they may be confident, we ask questions.'* (Student)

Being part of the consensus may bring a sense of confidence, but it may also lead to anxiety when confronted by the new. Asking fundamental questions challenges established consensual views. It is a different kind of confidence. In such a situation dilemmas arise. By raising a question a consensus may be challenged and shown to be inadequate. What happens if resourcing or power structures mean that the inadequate state of affairs prevails? (see Chapters 2 and 6). What happens if the questioner feels their job is at stake? Compromise, covert resistance, or 'leaking' become possible courses of action as alternatives to dialogue if dialogue is frustrated.

Dialogue rarely just happens (but see Chapters 6 and 9). It needs to be planned into the structures and processes constructed by an institution and the clinical placements to which it has access. One community-focused degree programme which the research team visited appeared to have a clear map of the dialogic problem structure (Figure 1.1). This was explored by a member of the research team through a sequence of theoretical memos and interviews during the course of the fieldwork:

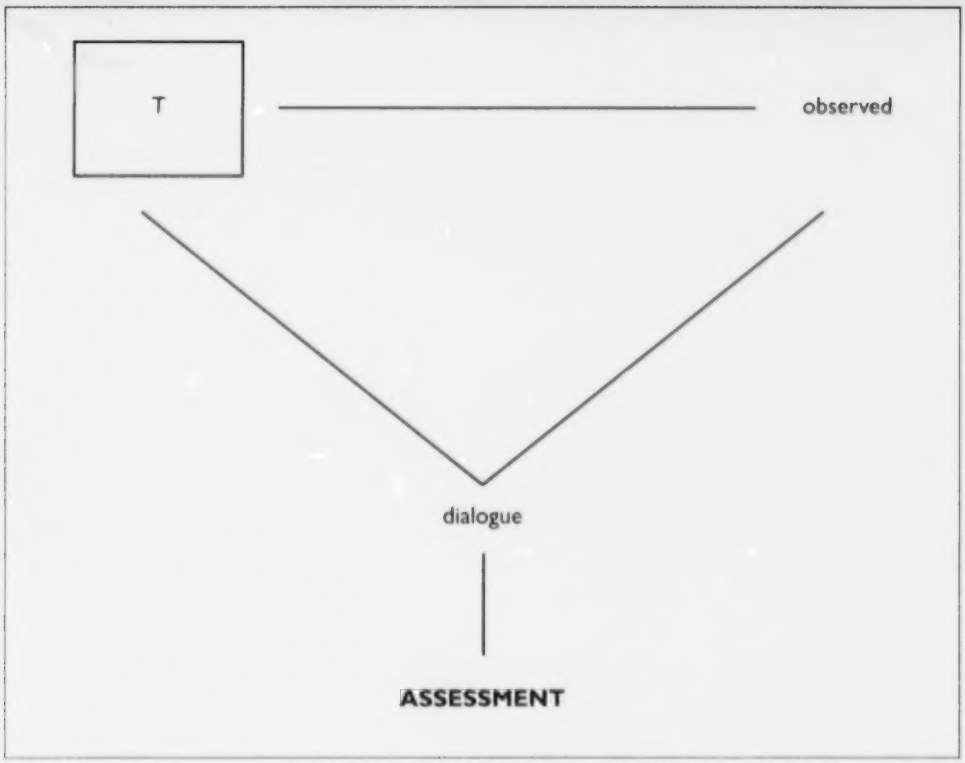


Figure 1.1: The dialogic problem structure of a community-focused degree programme

> *'Yesterday I drew a diagram of what appeared to be the model being operated here. The text (T) is a function of the assessee's ability to write up what was actually practised. The observation would then be a function of the CPTs [clinical practice teacher] ability to guide, "stand in for" the assessee.*
>
> *Dialogue is supposed to bring T and the observed into relationship such that both informs the assessment. I held a discussion with an assessee on a placement with a learning disability community practice and tried at one point to explore this issue with him.'* (Theoretical memo 6)

Although the structure appears to be present for establishing a dialogic approach to assessment, there are some notable areas of ambivalence and absence. Clearly, the writing of the text (T) depends not only upon the assessee's writing skills but also their honesty, attention to detail and lack of prejudice. Similarly, the observation depends not only on the assessor's ability to observe but also their preparation for this role, their honesty and lack of bias as well as whether they actually observed anything (see Chapters 6 and 9). Finally, not only does it matter whether a dialogue occurred but also what its quality was, its openness, toleration of difference and exploration of speculative alternatives (see Chapters 9 and 10).

What is absent yet always presupposed in the discussion so far is the field of practice itself in all its dynamic complexity; the text can only ever be a selection from and a particular interpretation of this field of practice. Trying to add this into the model leads to the next step in the sequence of theoretical memos (Figure 1.2).

> *'Assessment of practice can only be achieved through the variety of ways in which practice is represented. The main instrument is the profile written by the assessee. Hence assessees must develop a skill of representing their practice; this is backed up by the CPT who is a witness to the practice and the immediate results/consequences, and can also be backed up by clients' views.'* (Theoretical memo 7)

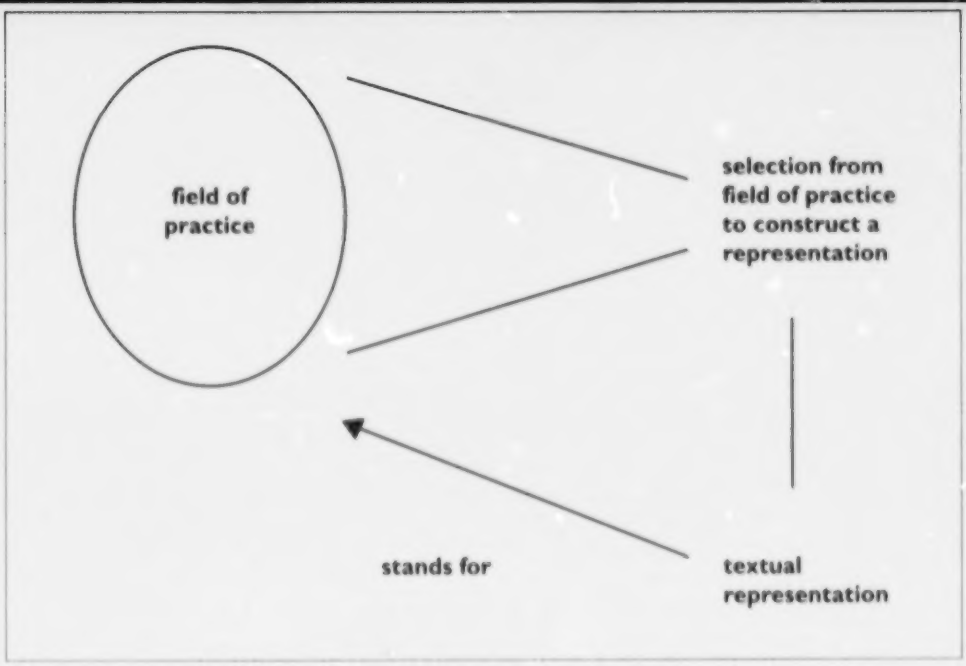


Figure 1.2: The next step in the sequence of theoretical memos

The construction of the text is thus a complex activity with implications for its status as an evidence base. Based on interviews with lecturers, clinical staff and assessees, the particular hospital on which these memos are based seemed to be operating a relatively sophisticated dialogic model, few other institutions either aspired to or achieved this degree of dialogic underpinning of the textual evidence base which in turn underpinned their assessment procedures. The final step in the development of the model is clear in the next theoretical memo:

> *'In an interview discussion yesterday with a senior member of staff, the debate moved to the notion that the profile (or textual representation) can be considered as a part of practice experience and as a product of it. This is because professionals need to be able to make their reasoning publicly accountable. Hence, reflection and the products of reflection are an integral part of practice itself. This then modifies the relationship expressed in the models [overleaf] [Figure 1.3].'* (Theoretical memo 8)

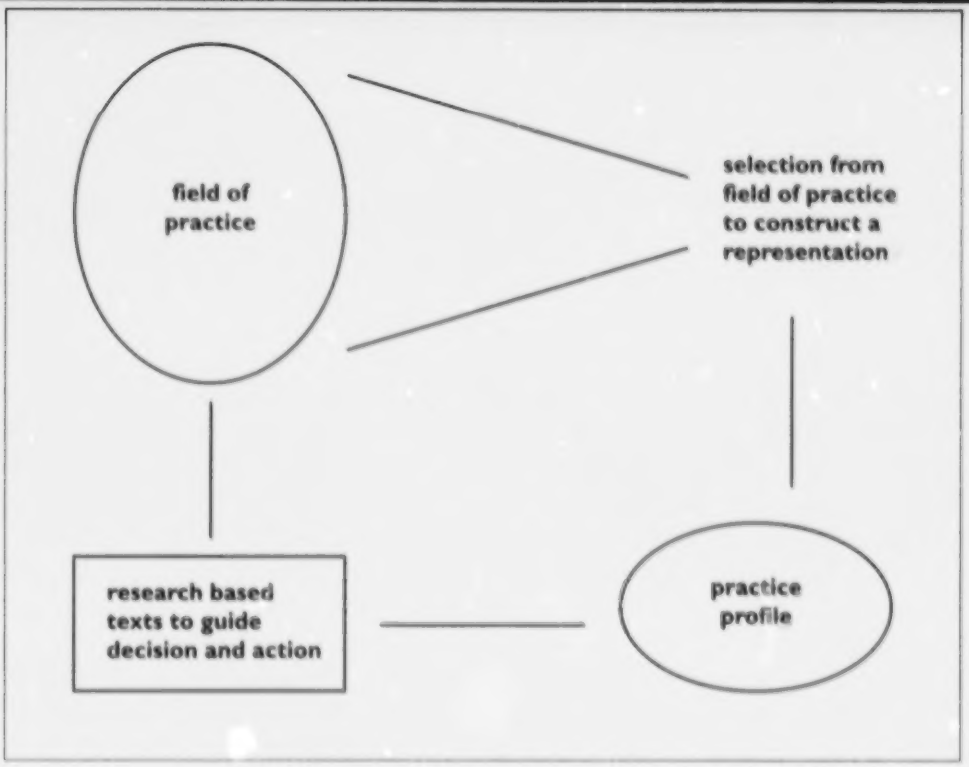
field of practice
selection from field of practice to construct a representation
research based texts to guide decision and action
practice profile

Figure 1.3: The effects on the model of the need for professionals to make their reasoning publicly accountable

Built into Figure 1.3 would be a notion that any texts produced are a necessary part of making professional practice research-based, and the knowledge expressed in texts as being in the public domain rather than the private domain of the professional's head.

> *'What clearly came from interview today with one of the designers of the present course was the resource required to underpin the above process. But not only that, that if the resource was not there then the course would not be possible and the practitioners which would result from a course that was not resourced in such a way to underpin the above cycle of reflection on practice would lead to qualified assessees in which she would have no confidence.*
>
> *This clearly has major implications for hospital environments which are in no way resourced at the level of assessees in community practice. The question then is: are there in hospital environments models which can underpin the above cycle? Is this where the lecturer practitioner comes in?'*
>
> (Theoretical memo 9)

This final step closes the gap between education and clinical practice. In many institutions visited education was clearly thought of as an 'add-on', an extra burden which took second place to caring for patients rather than as a necessary part of the process of care.

It was interesting to see variations of the above models employed by other institutions, particularly in the hospital environment. For example, after a telephone interview the following summary transcript was made:

> *'Tend to be the typical adult learner, they go in with overkill. You get a bit worried about the potential for over assessment. Not many of the assessees have taken advantage of the fact that the assignment they are writing could be evidence for some of the competence clusters. I think*

*more work has to be done on making links and connections between what's expected of assessment of practice and how that might be integrated with modular assignments. We wanted to move away from the notion that competence could only be assessed through direct observation. There may be circumstances when this is not desirable/possible, e.g., there may be an issue to do with violence/aggression or confidentiality. Written assignments are made available to practice assessors. "Triangulation" of evidence from other sources than just the assessee and the assessor. These may include testimonies from patients/clients, relatives, and others (non-nurses), in the care team, it could be simulations or reflection in the Learning Diary. Three points of reference expected for each cluster statement – Direct observation, evidence from Learning Diary and a question and answer session (oral).*

*Documentary evidence discussed between Assessor, Assessee, Primary Verifier and Secondary Verifier (Verifier = teaching staff): Secondary verifier used to minimise risk of the conflict of interest between the Primary Verifier (often the Personal Tutor) and the assessment process. Thought to be more objective. Differences of view do occur, on one occasion a dispute went as far as the ENB when some assessors expressed a vote of "no confidence in the assessment system" (assessee believed to have falsified evidence). The verification system is designed to deal with these conflicts of view. In practice Verifiers are reluctant to disagree with the decisions of clinicians. In fact course leaders have hinted in fairly strong terms, that once an assessor has made a decision s/he shouldn't really be questioned. They're worried about loss of potential placements.'*

(Telephone interview: Assessment co-ordinator)

The different approaches, and differences in resourcing and context have implications for what it is possible for the assessee to learn, experience, analyse and do.

## 1.5 Grounding the research agenda

The research employed face-to-face and telephone interviewing to ground the research questions in the concerns of practitioners, assessors and educators. It compared what interviewees said about their lived experience of assessment with what official assessment documents asserted it would be. The researchers engaged in dialogue with key participants throughout the research to explore the alignments and disparities between the two.

Following the initial period of 'grounded' agenda-setting, the research was carried out through intensive ethnography involving prolonged periods of observation in clinical work environments. As non-participant observers or (more rarely) in a participant role, the researchers shadowed assessors and assessees for a minimum of a morning/afternoon and a maximum of three days. They were again in regular dialogue with the practitioners with whom they were working, to check and supplement their interpretations of what they had observed. Through this dialogue they also gained insight into assessors' and assessees' reasons for their care-giving and assessing behaviours.

## 1.6 Co-constructing the theoretical framework for the research

The methodology that evolved for this research was 'dialogic evaluation'. This has two key principles:

- it seeks to identify the range of different voices, experiences, ways of seeing, doing and talking about the world to which the research addresses itself

- it aims to bring these into debate in order to explore alternative rationales and enhance the knowledge base by which judgement, decision-making and action are informed.

In this evaluation, the conversations between researchers and research participants contributed substantially to the shaping of the theory which informed the final research report and the framing of its developmental implications. So, too, did their observable behaviour. Consequently, the theoretical framework for the evaluation, which is presented as a number of models of (a) practice and (b) assessment, was a co-construction to be authenticated through further observation and dialogue.

Through this process of theory/practice, evaluator/participant interaction, the research team developed key concepts of 'situated understanding', 'fingertip (or embodied) knowledge' and 'strategic assessment'. This led in turn to the development of a model of learning and assessment which offers an alternative to many presently in use and to the production of a substantial critique of academic notions of levels in professional practice. Used to inform subsequent observations, the research model brought to the fore the context-bound nature of practice assessment and highlighted the need to more accurately assess practitioners' tactical and strategic responses to the immediate practice situation and the wider clinical context.

## 1.7 Collecting the data

The country was divided, for the purposes of the evaluation, into nine geographical regions. Telephone interviews were conducted with key educators and practitioners in each region, and questionnaires were sent to volunteer educational and NHS institutions across England. The information from these was analysed and used to create an initial (theoretical) framework for observation and analysis in clinical placement areas. Detailed observational data were then collected from clinical sites in each region to enable the construction of educational case studies. These sites were selected to ensure the inclusion of assessees and practitioner-assessors working with clients with different degrees of dependency in a range of forms of specialist care. The sample encompassed midwifery and all branches of nursing care, and sites included hospitals, hospices, general practices and home-based community care environments.

The majority of interviews were audio-taped and transcribed, although where circumstances demanded they were recorded as notes by the researchers. Observations were recorded in detailed field-notes made at the time of the observation. Tentative, formative interpretations of the data were made soon after the event in the form of research (or analytic) memos by the researchers, initially for themselves but also to share later with their fellow researchers. These became a form of data in themselves.

Because observations in placement areas could indirectly involve patients/clients, and took place on NHS property during the working day, access to clinical sites was always negotiated through local ethics committees (as well as through the senior nursing or midwifery manager for each area visited). In the majority of cases these committees were consultative and facilitated early entry to sites. Sometimes access was delayed for many months, however, when ethics committees either demanded further information or had to delay reaching a decision due to pressure of other work. One ethics committee reported that it was considering making a considerable charge to all researchers for considering their research proposals. Although, in the event this did not happen, members of the research team were extremely concerned about the implications of the first signs of an expensive, and potentially prohibitive, trend.

The evaluation involved reviewing institutional mission statements, curriculum documents and assessment schedules, and negotiating sight of portfolios with the assessees to whom they belonged. Given the promise of confidentiality, most individuals welcomed the opportunity to engage in a dialogue about their writing and the documents which framed their work as assessors/assessees. The researchers did encounter resistance at institutional level, however, from some organisations concerned about the health care equivalent of industrial espionage by

others who might have sight of their curriculum or assessment documents. This, like the issue of payment for consideration of research protocols by ethics committees, caused a degree of concern about the climate in which research is currently conducted.

Evidence from document study, telephone and face-to-face interviews, sustained on-site observation in clinical areas and continuous dialogue was brought together to construct (educational) case studies for the over-arching case study of the assessment of practice in clinical environments.

## 1.8 Analysing the data

Using dialogic evaluation, the researchers explored assessors'/assessees' understanding and experience of the world in which they live and work, from three dimensions; the conceptual, pragmatic and material. The conceptual – or discursive – dimension looks at the way ideas and 'embodied' knowledge are framed into belief systems and systems of (informal and formal) knowledge. The pragmatic dimension examines the way situated practices (including routines, habits and procedures) become embedded cultural practices. The material dimension focuses on the constraints imposed on action by levels of resource, including emotional and structural resources.

These three perspectives are employed to analyse fieldwork observations and participant commentaries in ways that make apparent the points where assessors enact choices. The analysis reveals where choices – and the actions associated with them – are informed by personal beliefs and understanding and where the key factors are material and cultural circumstances.

Emergent analytic categories were developed over time using on-the-ground exploration of interpretations with practitioners and assessees, and were further validated through a second stage of formative analysis in which the limits to generalisation were explored. Finally, the analysis was tested with individuals and groups not yet included in the sample set.

Without compromising the overall interpretative approach, the research team chose to take a number of different starting points for the data analysis. The range is preserved in the report. At one point, analysis was carried out on the transcript of a prolonged interview with a single practitioner-assessor; at other points, on sets of interviews. In the second part of the report, analysis centres around vignettes which, because they are clustered under category headings, have already undergone partial analysis. In addition, some vignettes are presented as a focus for considering alternative explanations of what happened, for reflecting on the constraints within which the actors were operating, and speculating about courses of action that might have been taken but were not.

The preferred analytical tool throughout was progressively-focused interpretative analysis. The researchers recognise the subjective (or, at best, inter-subjective) nature of interpretation by presenting their analysis as the focus for dialogue, at times encouraging the dialogue by offering more than one possible reading of a particular piece of data.

## 1.9 Representing the data

Researchers sometimes present data as if they were unmediated. Data are, of course, a product of interpretation and selection, even in the initial stages. The longer they are worked with and reflected upon, the more they become a mediated 'version' of events. This is not to suggest that the data become less valid, only that care must be taken with the form of presentation to avoid its gross mis- or over-interpretation. To this end, the writers of this report decided to present detailed examples of what was observed in clinical practice using a narrative (vignette) form of representation. The intention in doing this was to acknowledge the constructedness and partiality of what gets represented, thereby encouraging readers to share the particular instance as a version of what happens in the wider world. Observational data were represented, then, as an instance (or case) to be explored in relation to similar (but different) situations; not

as evidence that will lead to generalisation but as an example of interpretation in context. (This issue is addressed at length in Chapter 9).

## 1.10 Preserving the dialogic in the written report

One danger in writing a research report is that much of the inevitable 'messiness' of the research process, and the continuing debate about what it has revealed, is lost through a tidying-up process. Tidying up is done in part to assist readability and in part to allow the researchers to distinguish between what they take to be central and peripheral features. It is the aim of the writers of this report that this process does not mask either the way in which they, together with the research participants, moved back and forth between evidence collection, analysis, theorising and practice observation, or the way they as a team continued to build and modify or challenge the framework they were developing to understand the phenomenon of assessment of practice in practice.

The report moves between report, in which data are provided at length, to model-building in which the data are synthesised and a theoretical framework developed (drawing on existing theory but also creating new data-driven theory), and back again to report. As a consequence, several 'angles' are given on the same issue, levels being a case in point. The report also draws directly on analytic memos made by researchers at the time of the research, showing how ideas were shaped, modified and changed as the research progressed.

What follows in the rest of this report is an account which attempts faithfully to represent the complexity of the research process as well as the complexity of the research process as well as the complexity of the world it is about.

## 1.11 Summary

The different ways of conceiving the curriculum position the assessee either as driver or passive recipient of the agendas of others or as mutual agent in the educational dialogue or as a combination of these. Similarly, assessment is seen either as an add-on or as integral depending upon the ways in which the curriculum is conceived. The process of informing the judgement of assessees accordingly differs as to the form of curriculum construction chosen. Each form has resource implications such as:

- time available
- number of dedicated staff
- appropriateness of staff education for assessment and curriculum development
- resources available to assessees to facilitate the accessing of information
- ward organisation to facilitate dialogue, information flow, access to appropriate experiences.

This list is not exhaustive.

## 2.1 Introduction

How can we know whether an assessee has reached an appropriate standard? Standards are in essence context-free; they are objective, to be applied in all possible contexts. Yet, context is critical to learning in practice. Is there an irresolvable paradox here? If the curriculum is to be relevant it must draw from the realities of practice, and if assessment is to be relevant it must be appropriate to the practice curriculum. Curriculum and assessment are thus two sides of the same coin which is minted within the realities of the practice experience. If there are to be standards by which to judge the quality of the experience, the curriculum undertaken and the action carried out in practice, it would seem reasonable that they are drawn from the methods adopted to collect, analyse and validate evidence. This chapter draws upon contemporary research subjects' experiences within learning environments as a way of mapping the curriculum/assessment problem structure. It is argued that evidence relating to the quality of learning, curriculum development and assessment must be collected within the context of the realities of work and clinical practice and that to do this, attention must be given both to strategic and tactical issues in assessment.

## 2.2 The realities of work and clinical practice

Assessment procedures which do not start from an adequate conception of work and what it entails are unlikely to be appropriate to the education and development of practitioners in the workplace. Although it may be tempting to analyse work in terms of tasks, create lists of competencies and skills required, formulate routines and procedures to be adopted and specify information to be known, such approaches overlook the holistic, dynamic, personal, community and multi-tasking nature of work. Interviews will only go some way in providing insights into the nature of work and how the assessee may be assessed; it is essential also to observe and be alongside practitioners. Even then, there are limits to grasping the individuals' experiences, decision-making procedures and understandings. There is an existential quality to work which is difficult to assess but nevertheless undeniable in its brutal reality:

> *'Practice clearly implies a handling of the body. I've several times had descriptions of the initial fear of doing, where doing involves doing things to a living being. When those descriptions have been given they have often been accompanied by the more unflattering terms: fart, shit, vomit. Also it has been accompanied by images of pain and of the risk required to overcome the fear of dealing with a body and that person's pain, indignity. There appear to be two kinds of response: one is the reduction of the individual to 'bits' – a wrist, an ankle, a knee bone which needs to be 'cared for', i.e. a general de-humanisation; or to have the whole take dominance over the 'bit' as in the community nurse situation where entering a person's home is a symbol of being 'let in' through permission.'*
>
> (Researcher's theoretical memo: 10)

The memo records the style of learning that fragments the field of practical interest. These fragments ('bits') do not reintegrate into a whole. The 'curriculum of bits' essentially attempts to focus attention and cover only that which is necessary to the bit. This has implications for the resulting quality of judgement. Assessment is geared towards the bit and the knowledge, skills and judgements applied to it. The alternative to this is to address the whole. Here another kind of curriculum imperative arises and the strategies developed to ensure coverage of the knowledge, skills and practical judgement required are quite different.

The retrograde transformation of practice-based learning to a cumulative 'mastery of bits', and its relationship to a proven way of coping with stressful life-experiences (in this case one's own embarrassment, other people's indignity and the reality of the unpleasant nature of some component tasks) suggests more than the utilisation of a distancing strategy which protects the individual from the awareness which accompanies total knowledge – a realisation of the potential awfulness of the entire picture. There are distinct cultural overtones in nursing and midwifery, which developed from and alongside a medical imperative which traditionally has practised differential diagnosis by concentration upon bits of the anatomy, its underlying physiology or even the psychological components affected by disease. As the two professions sought to promote their autonomy and independence from the medical model, they espoused the concept of holistic care. We should consider why this more progressive philosophy apparently is being abandoned in the mastery of bits approach to practice and the learning which supports it.

Contemporary health care provision is dominated by a political agenda which has defined success in terms of numerical targets. While the rapid throughput of patients may mean that more individual conditions are identified and treated, it can militate against holistic care. Success is measured in terms of conditions treated, and the recipient of health care is reduced to a collection of symptoms, each lending itself to re-interpretation as a singular completed consultant episode.

The timing in relation to changes in nursing and midwifery education is a further factor in the pattern of fragmentation and integration in the model of learning which has developed. As programmes became more academically demanding, moving from certificate to diploma level and beyond, there was increased recognition of the eclectic nature of the required knowledge base, with a developing emphasis upon a holistic approach which acknowledged the contribution of a range of associated disciplines such as sociology, psychology, ethics, law and management. As academic content increased and intensified, less time was spent in the practice environment, with pre-registration students often experiencing a variety of very short placements; despite this, students must emerge from the programme as safe and capable practitioners. Pressure from service-providers, students and many involved in education resulted in the demand for proof that the required competency had been achieved across a range of activities: the holism advocated in the classroom represented by fragmentation and task-specific learning in the classroom.

In either case, a professional at work does not just imagine that he or she is in a situation, nor is one *generally* in a situation, one *is* in a situation, and it is *this* one. The concreteness of the circumstances matter. This kind of specificity at a tactical level may lure one to observe and evaluate specific tasks and routines and neglect at a strategic level the underlying principles, connections, theorisations which organise and guide specific actions.

Assessment at the tactical level may be one or both of the following:

- a systematic coverage of tasks and their sub-dividable components
- a positing of levels of task and job accomplishment which sketches a transition from beginner to expert, from supernumerary observer to competent participant.

Assessment at a strategic level is not so clear and is discussed in later sections. This is not to deny that there are perceivable tasks, skills and their components, nor to pour scorn on a common-sense notion of the staged transitions from novice to highly experienced practitioner. The issue is that closer examination of the actual work of professionals may provide alternative readings of level and expertise (see Chapters 6 and 7) and the transitions required for newcomers to take on the demanding role of the professional. A contingent question would be:

- What is the different/additional work of the qualified professional who is trying to develop the work they already do?

There are two linked key research questions here:

- What is the work of the professional?
- What is the work of the assessee who is trying to become and ultimately to *be* a fully functioning professional?

## 2.3 Doing the job

This section uses line-numbered transcript extracts as the focus for description and analysis. The extracts were deliberately chosen from one interview with a nurse manager of a very busy orthopaedic ward, in order to raise issues of practical judgement, resource, curriculum potential and assessment. Although this initially places the focus on hospital rather than community, and nurse rather than midwife experiences, points of comparison and contrast are discussed elsewhere.

### 2.3.1 Managing care and staff

Doing the job, meeting the demands of work, provides the employment and care context and specificity of circumstance for practice and education. Engaging people in telling the story of their daily work requires the multi-layered management of competing agendas, the unexpected and interruptions to plans and routines. The account quoted below typically divides between what is supposed to happen and what actually happens (lines 2, 37-38, 57-64). Any simple notion of a linear temporal structure soon evaporates. The mental construction of what happens must accommodate several time tracks. The time necessary for something to happen in one time track is faster or slower than another. Each patient or client has their own time track with their temporal imperatives – this must happen at this time, not that; social services have their demands and deadlines (Transcript 2, line 16); management has its time track; care, perhaps, has another. Resources also affect the construction of time; if they are inadequate, what ideally *should happen* only occurs virtually as a norm against which is measured what actually happens in real time (lines 72-79). Personal time along with time for education, teaching and reflection are too often sacrificed (see Extract 2).

The agenda and temporal running order for the day is constructed anew each day dependent upon the circumstances of the day. The day begins with a listing of who is available (line 3) to deal with a particular workload (lines 4, 8-9), and particular problems (lines 37-40). This phase may be called an analysis of circumstances. The next phase is to construct a strategy for doing this (lines 17-18, 57-64, 72-79). In the mind of the experienced professional these phases may be conflated as dimensions of a single act, a grasp of what needs to be done. Analytically, however, it is useful to separate them because it enables the structure and process of practical reasoning and judgement to be drawn out for curriculum-building and assessment purposes. The story continues:

1. **Practitioner:** *'OK we started at 7 o'clock in the morning, that's when our early shift*
2. *starts we do seven till quarter-to-three. We're supposed to have a 20-minute break.*
3. *Yesterday morning two of us came on the ward to start the shift and a*
4. *supernumerary um bureau nurse was sent to us who's never worked in*
5. *a hospital at all we have to train [them] … We have to train the bureau*
6. *nurses up as well you see as part of our thing our bureau, our bank does,*
7. *bank nursing. So that was it until 8 o'clock, we were the only staff on the*

*ward. We had 32 patients, three for theatre, one poorly post op, um so you take*

*handover, you get there at seven, you take handover from the night staff.'*

**Interviewer:** *'And who goes to that?'*

**P:** *'All of us are supposed to go.'*

**I:** *'Including the non-trained?'*

**P:** *'... everyone on that shift is supposed to go to handover so everybody*

*knows roughly what's going on on the ward.'*

**I:** *'To what extent do the not so trained understand what's going on?'*

**P:** *'Probably huh not a great extent most of the time but you'll also like the*

*ambulation state of the patient whether they can be up or whatever so that*

*to them is the bits that they pick out and they know whether they're a hip*

*or a knee or a wrist or whatever to give them a clue what they're nursing.*

*Um so you have handover which takes roughly between 15, 20 minutes.*

*Then the night staff go off and that leaves the day staff. Then you have to*

*do your drug round. So yesterday morning I did a complete drug round.*

*Normally we do team nursing. Say we have a split drug round we have 15*

*patients under the care of each team but because we were so short staffed.'*

**I:** *'Right so you'll have trained and untrained at each end?'*

**P:** *'At each end yeah. And then if you have the threes you've got whichever*

*team is heavier patient-wise care-wise the second trained goes there to that*

*team, to back them up so they have more trained input basically because*

*they've got more requirements for them. But yesterday obviously with two*

*of you on the wards you can't do that. So I did the drugs and then the*

*second trained member of staff prepared with this bureau nurse the*

*patients for theatre. We then got further bank staff.'*

**I:** *'But the bureau nurse could do anything because she's supernumerary?'*

**P:** *'No she's just follow, she's just following ...'*

**I:** *'She just follows around?'*

**P:** *'... that staff nurse around. Then we get further bank staff and one of our staff*

*on um who's an NA.'*

**I:** *'Right, but the further bank staff are trained, presumably?'*

**P:** *'No they're not trained ... there was a further three came on. Well there*

*was four originally then one got moved to another ward because they*

*didn't have any staff either. So we ended up with um 6 staff 5 of which*

*could work on the ward. Um, so you do your drug round. Then once the*

*drugs are done, the trained staff then obviously peel off. They ... ideally*

*khuh if you've got the correct amount of staff before you start your drugs*

*you prioritise the care for your team so you have a little team meeting*

*and say that needs doing this needs doing da di da di da ... Then you go*

*back into your team, um carry out care that needs doing e.g., dressings*

*removing drains things like, anything that you feel that you need to do, the*

*patient's personal care feeding them ... anything like that that needs doing.*

*You do that, that takes up predominantly most of the morning.'*

65.

66. **I:** *'You said ideally …'*

67.

68. **P:** *'Ideally.'*

69.

70. **I:** *'So what happened?'*

71.

72. **P:** *'Yesterday, however this didn't happen which was we didn't have any staff*

73. *so: I carry out the drugs the other trained member staff was trying to*

74. *prioritise the people that needed to be done, sorted out at the beginning of*

75. *the morning. And then, from there on in really, the untrained staff were*

76. *supervised by myself and the second trained was doing things like taking*

77. *all the clip, all the stitches out of wounds she was doing all of that. All of*

78. *that sort of thing. And the untrained staff were doing the basic care for the …'*

There is in effect a curriculum of the running order of the day that provides the tacit organising rationale for making sense of the day. The handover defines specific circumstances making sense of the 'bits', that is, the knees, wrists and so on. To fit in is to know the key circumstances and running order and to be able to join in. Being a bureau nurse and supernumerary excludes the individual from the running order and places her in a passive position of 'just following' (line 44). Just following sets up the circumstances for a hidden curriculum of exclusion and loss of agency. The 'master' professional knows what needs doing and can list them as a taken-for-granted series (line 60). For assessees and assistants to participate requires 'training up' (lines 4-7) so that they understand the running order of the typical day and can prioritise according to circumstances. This can be seen particularly in the 'bad day' (below). Against the ideal running order, the real running order is constructed through continual reprioritisations. Again assessees and assistants have only a passive role to play.

### 2.3.2 A bad but typical day

The bad but typical day is constructed around an organising principle of basic care (lines 3-12) carried out in conjunction with a proposed running order (lines 29-42). However, both basic care and the routine become disturbed by a particular problem: the lack of beds due to inadequate social services support for patients who should be going home (lines 12-19, 22-24). This leads to a reprioritisation (line 13). Prioritisation is required for making sense of what to do next when there are scarce resources. The problems in this extract, however, fall within a normal range in that they are attendant on the expected increase 'at this time of year' (lines 19, 22-24). The task is to manage outcomes through the manipulation of available resources, procedures and mechanisms under key principles of practical reasoning adopted on the ward. The judgement process is illustrated schematically in Figure 2.1.

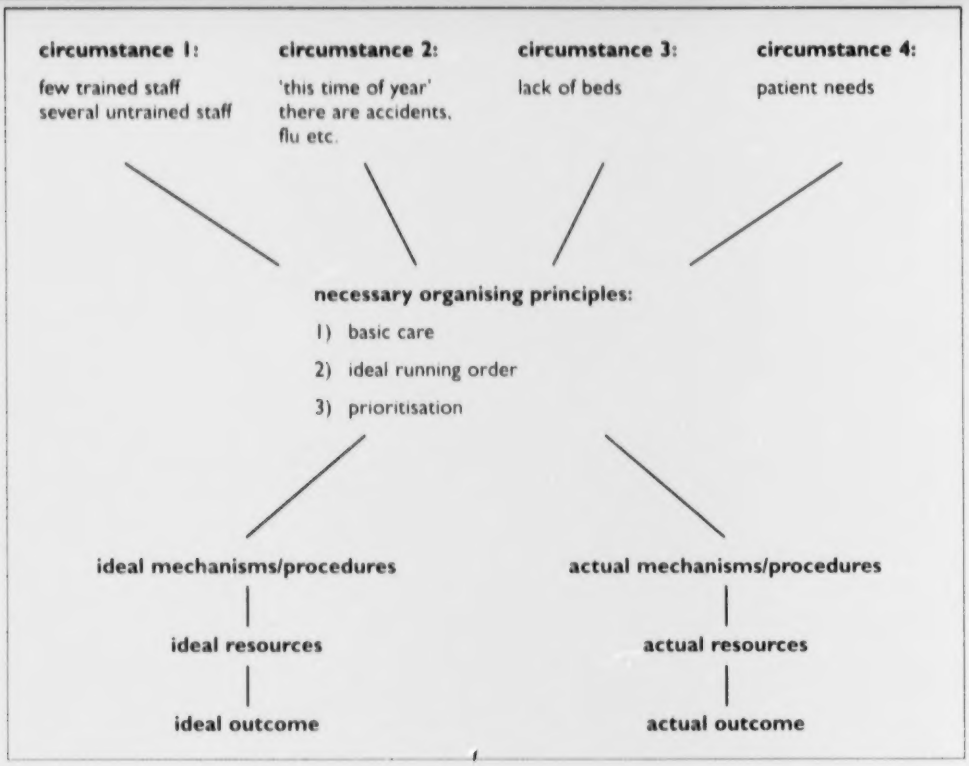


Figure 2.1: The judgement process involved in manipulating available resources

Crudely, the circumstances are analysed and are brought under the ruling principles of the given professional occupational culture of the ward. Tactically, two sets of mechanisms and resources may be employed to manage outcomes to achieve the governing principle of basic care. The first is the ideal; when this is not possible there is the actual. What is remarkable about a bad but typical day is that it is managed and on the surface there is a successful outcome that enables the next day or shift to begin with the hope of following a normal routine. Yet the cost is there in the form of lost opportunities to care, teach, learn and improve the quality of professional action through reflection. There is also a cost in that there was no time for a real break (lines 41-44) and patients are left waiting (lines 33-36). These costs are illustrated in many other examples throughout the report.

It is important to describe such days because they begin the process of countering any naïve belief in the assumptions implicit in many models of practice-based learning. Fundamentally they assume there are adequate resources and time to engage in cycles of reflection and on-the-spot supervisions and teaching by qualified staff. Finally, assessment is typically founded upon the assumption that there is a simple one-dimensional smooth progression from beginner to competent professional that can be managed year by year from Level 1 to Level 4. As later evidence indicates, this is not usually the case.

The next extract, which continues immediately from the first, begins just as the clinician has introduced the concept of basic care:

1. **I:** *'Right, what's basic care?'*
2. 
3. **P:** *'Um most of our patients being um elderly there's a high majority of them that*
4. *are confused and senile so they need feeding, they need complete*

*washing um if they've actually got fractured limbs they're, they remain in*

*bed rest so the whole bed needs changing. It's just everything really from*

*mouth care, feeding anything, putting them on bedpans all that sort of*

*thing. Giving suppositories etc. etc. we do that sort of thing but obviously*

*we need to know who needs enemas and all the rest of it to make sure that*

*they don't get impacted, all that has to be done. Um [so we were doing*

*that] while the literally the NAs were just washing and sort of clearing up*

*our mess if you like, what we did. Um by 8.30 I had three patients in A&E*

*and I had no beds. So then I had to prioritise my care as my*

*management point, um inform my manager I had no beds and that I had*

*nowhere to put any patients um and then spent the majority of my shift*

*yesterday actually chasing social services to try and get them to allocate*

*patients that had been referred to them 72 hours previously a social worker*

*so that we could then get these patients home because I have nowhere to*

*put them and we had no beds in the whole hospital .... This is normal*

*this time of year, we don't have beds because it's just this time that people*

*fall over they've become ill and they get flu and things, they're poorly they*

*trip over going to the loo whatever. We have a huge influx plus there's*

*um, we've got a lot of um road traffic accident victims at the moment*

*because of the bad weather. Lot of major one's we've had. So obviously*

*they're not moving.'*

*[The aim is a 10-day stay for a typical client – a lot are 'hanging around' – one was a*

*month]*

**P:** *'So that was basically what I did for the rest of the shift was just trying to*

*sort out social services and trying to get people home and by the time I went off shift*

*I'd actually managed to get four people home and transferred two people out into beds that*

33. *up um to, an ophthalmic ward, because they were going home the next couple of*

34. *days, so that I could then get my casualties in that had been sitting in A&E since*

35. *8.30 that morning. They'd been actually in the day surgery unit on a bed but you*

36. *know they'd been in transit since then. Meantime we had to do another drugs round.*

37. *You're supposed to supervise meals and ensure that everybody's fed um being*

38. *orthopaedics, being that they're in bed all the time we then also carry out pressure*

39. *area care so we do our 30° tilts etc. Um then we do handover again to the late*

40. *staff that come on about um quarter-to-two. And then you're supposed to go off shift at*

41. *a quarter-to-three. Um and in amongst this you're supposed to have a break somewhere.*

42. *Well I didn't actually succeed in getting any break at all yesterday. I only got one*

43. *cup of coffee sneaked round in the nurses station. Um plus organising all the breaks*

44. *for all the other staff and doing anything else that happens to … I had to sort out a*

45. *transfer to [location] for an outpatients appointment and things like that as well. Sort out*

46. *ambulances etc. So that was a typical, that was a bad but typical day.'*

The order of the day must be composed in relation to the ideal or normal running order. The transcript extracts provide some insight into this process. For example, the university and assessee each have their own agendas and time periods within which to achieve them. These impose upon the running order of the clinical area which leads to a reprioritisation or a neglect of the assessee's needs. Due to bad weather there are, for example, more accidents in the community, or due to poor housing there are more illnesses which leads to a demand on the ward which cannot be ignored. The process can be continued. Social services as an external agency has its problems which in turn leads to problems on the ward because beds cannot be freed. Each such problem leads to reprioritisations which finally construct the actual order of the day.

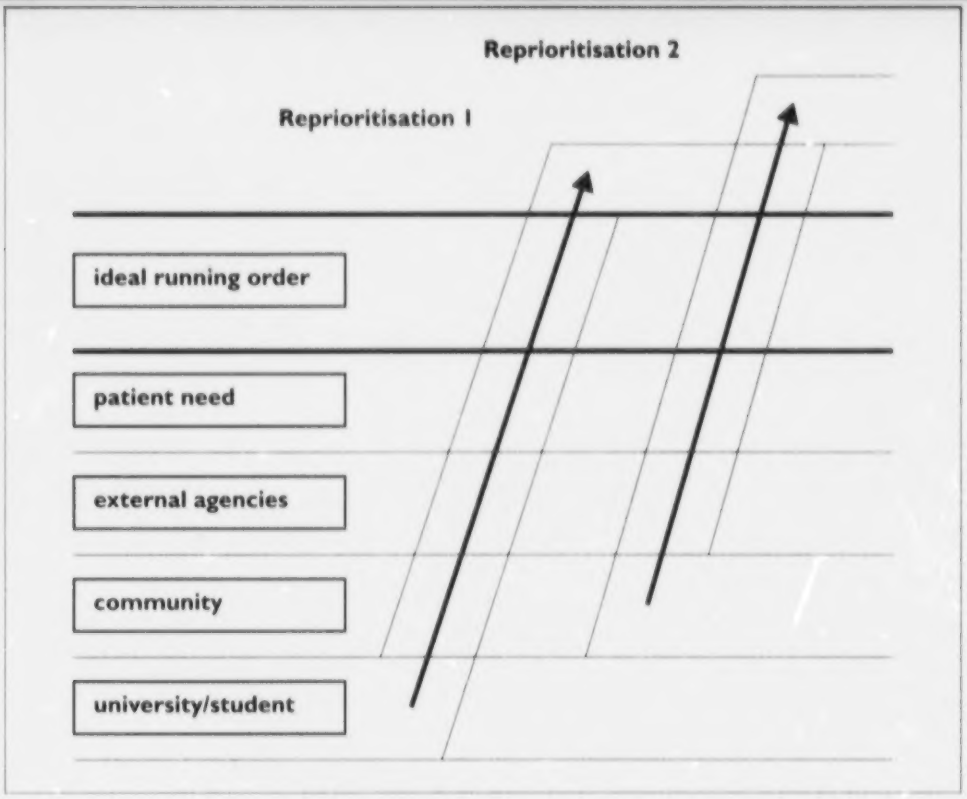


Figure 2.2: The process of reprioritisation

The effect of problems impinging on the supposed running order is to create a continual sense of urgency. Assessees arriving on such wards often express bewilderment, anxiety, indeed fear as they get caught up in the apparently confusing cross currents.

### 2.3.3 Managing learning

Figures 2.1 and 2.2 schematically describe the factors influencing practical judgement, albeit crudely. Arguing for a principle of education to be included in the framework of practical judgement in the context of ward management and desired outcomes is clearly not easy. Education demands principles for the construction of a curriculum of practice and the appropriate forms of its assessment. This in turn demands appropriate procedures, mechanisms and resources.

The initial task is to manage in some way the entrance of the assessee into the ward:

> *'We try to have two preceptors for a student so in theory whatever shift they're on there is a preceptor that belongs to them in this shift. Um so they come down and they meet us before they actually start working or being on the ward and they you know they, so they know who we are … Although the ward's a strange environment as such when they come on to it the first day they're working or placed there, it's not quite so strange because they have actually seen some people although they don't get a formal sort of walk round the whole ward that day, the ice is sort of broken. They're aware of who's who which helps I think with the fear element. Um and then I try then to sort of chat to them about, depending on whether they're rostered or non-rostered what they want to do.'*
>
> (Practitioner)

Remarks by assessees (reported in Chapter 6) make clear that support for facilitating entrance is frequently lacking and difficult to achieve. The description of the day's work quoted

make clear the pressures, competing priorities and the lack of qualified staff time that may be available to work with an assessee.

The strategy of managing the assessee's learning depends upon their prior experience:

> **Practitioner:** *'I wouldn't expect [first-years] to be getting involved in management as in discharges particularly. I would be looking at them to sort of… gain knowledge of basic patient care and including the operations etc. so there's the option of them going to theatre.'*
>
> **Interviewer:** *'… How do they gain knowledge?'*
>
> **P:** *'They follow us. Basically, they shadow us when they're non-rostered. Um if, depending on their confidence, I mean the first week they shadow us. We just say to them follow us, doing whatever we're doing, see what we do.'*

This extract already assumes particular levels of knowledge and confidence:

Level 1

- **Circumstance 1:** first-year assessee, therefore no confidence
- **Organising principle to be learnt:** basic care
- **Action:** use procedure of following/shadowing experienced staff
- **Outcome:** increase confidence.

Level 2

- **Circumstance 2:** post-first-year assessee, therefore some experience of basic care
- **Organising principle to be learnt:** management of care
- **Action:** involve in discharges etc.
- **Outcome:** (not stated).

At Level 1, the initial tasks for the assessee are about getting to know the staff, building up confidence, and learning to follow certain activities; this might be called a curriculum mapping phase. How may such a process of mapping be carried out, and what are the precise mechanisms/procedures and resources employed by assessees and staff in clinical areas? Later chapters explore these questions in more detail, and re-examine the notion of level in practice. For now the focus remains on the contextual realities constraining educational processes.

In getting to know the context, some first-year assessees prefer to observe, others to participate as much as possible. This assessor prefers those who are willing to join in:

> *'… because I find that learning comes out of it you know they'll ask you a question about something you're doing and then you can go into why you're doing it, the background of it. You can then pick their brains and see what that, you know can they pull their theory from the classroom into whatever. Have they any knowledge of it at all because sometimes they don't have any knowledge. And I find, it's um, it's easier to teach somebody that appears to be more interested. If somebody tends to just stand there and just watch you all the time it's very had work. It's very wearing trying to think of things to sort of teach them as you go along.'*
> (Practitioner)

Curriculum building is thus based on practice elements. However, what is mapped depends on the attitude and agency of the assessee as much as that of the assessor. It is a process of asking questions about what is going on at the moment, in which both sides need to be able to structure learning opportunities when carrying out tasks. However, this is bounded



40

by its own temporal requirements and thus has the effect of slowing down the execution of the task itself:

> *'Sometimes you say to them come with me or whatever and then they're come with you and you know you haven't really taught them as well as you could 'cause you just haven't physically got you know, you're experienced with dressings so you open the pack you do them , it might take you sort of 10 minutes to do a dressing, even shorter once you know the dressing yourself as well and the patient. Whereas a student will obviously take longer because they're … they're not as practised.'*
> (Practitioner)

She states that where it might take five minutes for qualified members of staff, it would be more like 45 for an assessee. This would be impractical, if not dangerous, within the context of a typical but bad day. Even on other days the sheer busyness of the ward can prevent the kind of time she would ideally like to give to assessees (see Chapter 6). Indeed, she said that she regarded only about 20% of her learning interactions with assessees to be of the standard she would feel to be appropriate.

> *'It's just very physically wearing to do all these roles and you're not getting support for doing them, you're not getting any extra staffing so that you can do these roles … and when it comes to patient safety I'm afraid obviously student teaching goes right out the window. If it's patient care and patient safety versus teaching your student, your student loses out.'*
> (Practitioner)

This kind of comment is made by clinicians, lecturers and assessees across the country. Its very pervasiveness must give rise to doubts as to whether clinicians who are not employed predominantly to teach and thus prioritise teaching and learning should act as an assessee's sole assessor. Role conflict is difficult to overcome and its impact on assessment needs to be explored in more detail. This turns to the realities of assessor circumstances that reveals itself in terms of role conflict.

## 2.4 The problem of role-conflict

Evidence from both observations and interviews conducted during this project suggests that the problem of role-conflict is widespread, serious, unresolved and increasing. Although its severity will alter with circumstance, conflict exists between the role of the assessor in relation to the assessee and other demands inherent in their work. These elements of possible role opposition may be described in terms of conflict within the educational components of the role, assessor/carer conflict where this involves dual responsibilities, with role-conflict arising from or compounded by resource issues and conflict between educational (assessment) elements and managerial or administrative responsibilities.

### 2.4.1 The assessor as supervisor

The role of the assessor in the practice environment never appears to be limited to that of assessment. Continuous assessment has all but replaced identified assessment exercises, reducing the scope for ostensibly objective assessment of predetermined activities, although single-task skills assessment is still performed in some post-registration and increasingly again in pre registration programmes. Longer time-scale management assessment (usually for the duration of an entire shift) still occurs in some, particularly mental health branch, pre-registration programmes, but the assessor is usually prey to the same educational role-conflict which colours so much assessment in practice.

The difficulty which arises pertains to the multiple educational role function performed by the assessor. In many cases this person is also the assessee's clinical supervisor. While it may

be argued that a close supervisory relationship will have ensured that the assessor is in an excellent position to know the assessee's strengths and weaknesses, it may not be the most satisfactory preparation for an assessment of that assessee's practice as it may cause a degree of assessment bias, whether positive or negative.

### 2.4.2 The assessor as teacher

Even more common is the element of dissonance which occurs between the roles of teacher and assessor. Inextricably linked in current preparation for the role of assessor is the teaching component of responsibilities. Nurses and midwives are very familiar with teaching in practice – they derive an enormous proportion of their own clinical ability from teaching received on the job.

Clinical ability is perceived as competently performing skilled procedures and reacting in an appropriate professional manner in the clinical environment. Assessors who have worked with the assessee will have used these techniques of teaching by showing, telling, exploring and adding to the assessee's knowledge-base, and acting as appropriate role-models. Their assessment of the assessee's practical ability is likely to be based upon this, with judgement influenced by their perception of how much the assessee needed to be taught or shown. Some difficulty arises from assessors not knowing the extent to which they can divorce an assessment from the teaching which preceded it or is conducted concurrently with it. Among all those interviewed who were asked about their role, the function with which they felt most comfortable was teaching, not assessing. There is thus a perceived split in these key dimensions of the educational process.

### 2.4.3 The assessor as subject expert

Role conflict may also arise where the assessor has internalised criteria which are incompatible with the educational philosophy of the curriculum. An example from fieldwork observation is where a district nurse assessing child branch assessees rejected the concept that they should analyse and reflect upon the sociological impact of health care decision-making in the community, preferring to base her judgement upon the ritualistic performance of a range of psychomotor skills necessary to provide elements of hands-on care. This assessor's non-compliance with the desired educational approach reflects more than a need for greater involvement in curriculum planning and preparation for assessment. It is evidence of a significant area of role-conflict between the ideals of the educational establishment and her own perception based upon her experience of the work, of the skills needed to be an effective community nurse and the recognition by her of a corresponding knowledge-deficit among the assessees.

### 2.4.4 The assessor as assessee

There is a further example of educational role-conflict where the assessor is also an assessee, which can occur where an experienced practitioner is undertaking a post-registration programme. While this may not cause any conflict beyond that of time-demands, there is a capacity for divided loyalties and a feeling of resentment if the assessor's own experiences have to be compromised to provide the extent of assessment and supervision required by the assessee. An example of this from practice is where a midwife acting as assessor felt she had to forego the opportunity of having her own suturing technique assessed following an episiotomy, as she was engaged in the supervision and assessment of the assessee who had assisted with the delivery.

### 2.4.5 The assessor as carer: putting patients' needs first

Some conflict between the roles of assessor and carer appears almost universal. Nearly all those contacted for this project reported difficulties in balancing their obligations to patients and assessees, or affirmed their primary professional function as being to provide patient care. Despite acknowledging the issue of succession-planning – that preparation of today's assessees is essential for the continued ability to respond to patients' needs, *no-one* could conceive of a situation where the need of an assessee would supersede that of a patient.

An example from practice comes from a medical unit in a district general hospital. The assessor and assessee (adult branch diploma course) were providing care for an elderly woman whose metastatic cancer was in the terminal stage. The patient's condition was deteriorating rapidly and she required immediate pain relief. The assessee's learning objectives required her to gain experience of providing total care for such a heavily dependent person, and the specific skill of intramuscular administration of drugs. The patient was in pain and required more immediate care than the inexperienced assessee could perform. By taking the lead in working with the assessee, the assessor could speed up the delivery of care a little, but decided that the administration of the drug was imperative, and did this herself.

Similar solutions achieved through compromise are familiar to assessors throughout the service and reflect the priorities assumed as valid in the role they occupy. Assessees must be prepared to function within this culture, and *the problem of role conflict may be even more pronounced for them.* They are exposed daily to a culture of care, an established priority – putting patients first. The clinical teams and their assessors provide a consistency of approach: there is no shortage of role-models. Their own background, however, does not mirror that of many of their colleagues. Their student-base is in higher education and increasingly their peers and teachers inhabit a culture which may seem alien to those whose entire working experience has been in the old NHS. In order to survive, new students must quickly adapt to being a part of both worlds: articulate and assertive in identifying their learning needs, yet able to subjugate these within the workplace culture to assume the professionalism which will continue to put patients' needs first.

### 2.4.6 The assessor as carer: one-to-one support of the patient

Role conflict can exist for an assessor working in a clinical capacity which normally demands extensive one-to-one support with individual patients. This may be ameliorated where a named-nurse approach is operational and both the assessor and assessee act as named nurse for the patient, but this seldom applies, as it is too resource-intensive to be practical or the clinical condition requiring one-to-one support means that care may be compromised by the introduction of a third party.

An example from practice is where the assessor in a mental health unit is providing one-to-one care for a girl with a profound eating disorder. It has taken weeks to establish the appropriate rapport by the rota of nurses who befriended this client. Each had to build on this relationship to ensure a consistently high standard of individual care. The assessee has been allocated to the area for 12 days over a three-week period. All other assessors have their full quota of students and reluctantly this assessor has assumed responsibility for the assessee. She is only able to work with him on the rare occasions that another named nurse for the girl with anorexia is on duty, without compromising the rapport she has established with this client.

### 2.4.7 The assessor as carer: dealing with confidential/sensitive issues

Role conflict arises for the assessor when confronted with a sensitive situation in which a confidential disclosure may be imperative for the safety or wellbeing of the patient or others, and which could be jeopardised by the presence of a third party. While the experience may provide the opportunity for valid and extremely useful learning, the over-riding priority must be that of safety. An example from practice is where a health visitor assessor did not allow a child branch assessee to accompany her into the home of a young mother where she suspects that a child protection issue may be involved. Although the health visitor prepared her assessee for this and used the opportunity to explore child protection issues, the opportunity for the assessee to witness her acting as a role-mode in this difficult situation was lost.

### 2.4.8 The assessor as carer: support of relatives

Role conflict can occur where assessors find that the presence of an assessee interferes with the spontaneity of a response to relatives in need of immediate care and support. The

practice example of this involves the relatives of a patient on an elderly care ward who had sustained a catastrophic cerebrovascular accident. They looked to the assessor, the ward sister with whom they had built an established relationship over the patient's long periods of care, to support them. The assessor had to relinquish supervision of the assessee to provide a level of personal care which no-one else in the team was equipped to do.

### 2.4.9 The assessor as carer: support of other colleagues

Role conflict also arises when assessors have to suspend activity with an assessee to support another member of the team. Although many assessors confirm their determination to put concern for their assessee first, the situation can occur when the assessor is the most appropriate and possibly the only person who can provide that support.

An example from practice is on a busy neonatal intensive care unit where the condition of a baby suddenly deteriorated. The consultant was summoned and appeared to question the medical intervention instigated by the junior doctor. The baby's condition was stabilised, and after delivering a series of complex instructions, the consultant left. The junior doctor, tired and distraught, turned to the assessor, not just for support in establishing the new regime of care but also for a level of personal support she felt only that nurse could provide. Clearly the assessee was in the way and had the sensitivity to busy herself elsewhere. The assessor acknowledged a divided sense of loyalties here, perhaps recognising that in prioritising the needs of both doctor and assessee, she had unwittingly provided that assessee with a lasting role-model: the nurse as valued support in the wider multidisciplinary team.

### 2.4.10 The assessor as carer: member of the ward/community team

Membership of a ward or community team brings its own aspects of role conflict. In contributing to the overall efficiency of a caring unit, assessors may have to relegate to secondary importance the support and assessment of their assessees. An example from midwifery practice is where the assessor left a student midwife to staff the reception of the ante-natal ward while she helped on the busy delivery floor. Pressure of work elsewhere in the unit meant that the assessor had little time with her assessee, who stayed in the empty ante-natal area in case any patients wee referred from the clinic.

### 2.4.11 The assessor as carer: relationship with the multidisciplinary team

Role conflict can arise where an assessor's status or experience within the multidisciplinary team is such that in a given situation the performance of that function becomes an absolute priority. The assessee's needs may have to be suspended for the duration of the situation and it may not even be appropriate for them to be included in the activity. The example of this is again from the neonatal unit, where a child suffered a cardiac arrest. As an experienced neonatal nurse, the assessor had to co-ordinate the emergency resuscitation. Space around the incubator was quickly filled with medical personnel, life support and X-ray equipment, leaving no room for the assessee to observe. In discussion following the event, the assessor admitted to feeling that, in those circumstances, all the assessee could have learnt was that she and her education were expendable, that she was in the way and that the assessor had a more important role to fulfil.

## 2.5 The assessor as carer: where this is a resource issue

Significant role conflict can occur for assessors who wish to work with their assessee but are prevented from so doing due to an inadequate number of nurses on duty. This may be compounded where the nature of care requires patients in a unit, and each nurse looking after them, to be geographically separated; for example, when single cubicles are used where patients

are immuno-suppressed or pose an infection risk. In an example arising from practice, in the paediatric ward of a district general hospital, the staff nurse/assessor spent an entire shift administering chemotherapy and providing concentrated care for a terminally ill child in one cubicle while her assessee performs a similarly sustained level of care for a six-month-old baby being reverse barrier nursed in another.

A further example of conflict, originating from a scarcity of resources, is where there are insufficient assessors in the clinical area. In this situation, the assessor may have to divide his or her attention among a number of assessees concurrently, with a dilution in the individual supervision possible and the potential for divided loyalties and possible jealousy among assessees.

### 2.5.1 The assessor as ward/team manager

There are conflicting demands and priorities for assessors with substantial managerial and administrative responsibilities. They may not be as consistently available for assessees, limiting their opportunities to work together in a caring, clinical capacity. While the assessee may have less opportunity to practise and hone clinical and procedural skills, assessors can provide a valuable role-model demonstrating the application of their practical expertise to a range of managerial problems and decision-making. Provided both assessor and assessee are aware of the validity of these skills, there should not be any cause for continued role conflict.

### 2.5.2 The assessor as sole/senior trained staff member

In this situation where the assessor is the sole or senior trained member of staff on duty, the role conflict which may occur has similarities with that of the manager/assessor as the assessor may have to fluctuate between a clinical 'doing' and a management role. It is, however, more likely to be subject to constant interruptions from a variety of sources, over which the assessor has little control. Whereas the manager/assessor can determine a pattern of working in which it is possible to set aside time to on working with the assessee, the senior nurse or midwife is unlikely to be able to do so. He or she will have to contend with numerous distractions from the role of assessor; some occurring simultaneously, entailing constant prioritising. While this in itself is a valuable role for assessees to observe, it may cause frustration and conflict for the senior nurse anxious to complete an assessment.

In one example from practice, the only staff nurse in an elderly care ward conducting a final assessment session with her assessee was distracted on 26 occasions: to attend to patients, deal with queries from relatives, colleagues, a clerk, maintenance engineers, a security officer, technicians, porters, telephone enquiries, domestic services, Red Cross library assistants, a liaison health visitor and a trade union representative.

The potential for role conflict is acknowledged and its experience in a variety of manifestations is a reality for many assessors and their assessees. Role conflict in the workplace has been found to be a reality for the majority of participants in this study at least for some of the time during which they are engaged in assessment-related activity. Its extent and effects are as variable and as individual as the subjects of the study. The external variables are legion, and it would be futile to speculate upon the feasibility of a quantitative analysis of data which is so rich and varied in terms of the veracity of the working situation it portrays and which is open potentially, but never realistically, to the sort of scrutiny which could be imposed by a plethora of time and efficiency measurements, bio-scientific recordings and psychological stress inventories.

Role conflict has been shown to be a fact of life for nurses and midwives working in the clinical environment. While proposals to reduce its impact upon the assessment process are to some extent an expected and justified outcome of this study, it may be that a more salient approach would investigate ways in which such role conflict could be managed effectively and this aspect of the phenomenon should be acknowledged as an essential component of the 'learning to practise' experience and should become the focus of work-based assessment.

## 2.6 Implications

The analysis of the day and the role provide two important points of entrance to the mapping of work issues, and a curriculum of reflection, study and action in order to elaborate issues in terms of what is known, what needs to be known, what to provide coverage of and what to explore in depth. This mapping can provide the guidelines for collection of evidence about the conditions under which learning and assessment take place. The process of doing this is the topic of Chapter 3.

## 3.1 Introduction

Work, essentially, refers to both the conditions under which evidence is collected and the source of that evidence. It is the integrative processing required to transform information into knowledge and knowledge into action in order to bring about some aim in the world of ideas and material outcomes. If assessment is to be relevant to accomplishment in the world of work, it must be sensitive to each dimension of the process and have strategies for evidence collection that will inform decision making.

In current practice, evidence of learning is constructed formally around assessment documentation and informally around:

- assessee conversations with qualified colleagues
- peer conversations or passing comments.

The key questions are: what is the evidence that is being collected evidence of, and what alternatives are there? This chapter focuses on the issues associated with identifying evidence of skill, competence and levels of practice.

## 3.2 Assessment strategies

The structure and quality of the evidence recorded in official documentation varies as described in Bedford et al. (1994), which led to changes in assessment regulations. One of the changes was an increased emphasis on portfolios. These and the way their use has been constructed in practice as a form of closure rather than data for discourse are discussed in Chapter 7. Another was the increased importance given to triangulating evidence. This issue is taken up throughout this report and its problems are discussed in this chapter in connection with the need for dialogue. Evidence collection, if it is to inform judgement about the quality of practice for a given assessee must adopt appropriate tactics in relation to agreed educational strategies. For example, when lecturers interviewed seem generally satisfied that the assessment documents reflect the important elements of practice identified in the curriculum and provide a useable tool to measure and chart their achievement, what does this mean in terms of its suitability for assessment purposes? In strict terms, this is data only about lecturers' views or perceptions of how they value the documentation, not the quality of the documentation itself. Inferences may, of course be made about the quality of the documentation dependent upon the trust or value given to the lecturers' judgement.

In order to build such trust the criteria for judgement need to be explored. Such criteria are at a strategic level of thinking about assessment. For example, there are concerted attempts by education staff to produce documentation that is comprehensive and applicable in each relevant clinical environment and address the priorities of these areas. This typically involves discussions with clinical staff; this may be called strategic coverage tailored to a given clinical area. More tactically, the documentation itself needs to be structured to ensure, for example, that the assessees' preliminary exposure in each placement will focus upon orientation to the area and an awareness of safety procedures before progressing to more specific clinical experiences. The tactical elements thus move towards the particular steps required by assessees and/or staff. In particular, meetings are to be scheduled periodically for assessment to take place in order to monitor an assessee's progress, identify the remaining learning needs and, if possible, to address them by the time the final part of the assessment document is completed (however, Chapter 6 shows that it often does not happen). Depending upon whether the strategic philosophy of the programme is to encourage agency by the assessee or to so control the assessee's learning

experiences that they are rendered passive, the actual outcomes will differ even if the tactics look the same.

The assessment strategy usually involves a system of continuing assessment. However, some programmes also provide for single items which are formally assessed in a once-only approach. For example, a ward management component is retained in some pre-registration mental health branch programmes, and such single task skills performance as may be required on some specialist programmes such as the ability to conduct a cervical smear for cytology in family planning or practice nursing preparation. These discreet skills are often listed within the assessment document or a separate skills booklet which also requires completion by the assessee and clinical assessor. Many of the lecturers interviewed felt that this allowed all the important aspects of practice to be observed and assessed whether these were complex combinations of interpersonal and clinical judgement or the safe performance of isolated manual and technical skills. Again, the predominant issue in the minds of the lecturers in strategic terms appears to be coverage.

What, however, about the strategic issue of integrating theory and practice in the assessment process? Many determined attempts have been made to use a comparable form of assessment for both elements: instructions in many assessment documents detail how the recognition of achievement should be designated. Approaches include a description of the components of a particular aspect of competence or those aspects necessary to merit a particular mark or grade.

Strategically, the integration of theory, and practice demands reflection upon and analysis of clinical experiences. At a tactical level, this may be charted by:

- the assessment documentation
- the production of portfolio material with an additional format for any assessed content to be recorded.

Generally, lecturers acknowledge the difficulty of achieving integration and balance between the theory and practice components of learning, recognising the pressures which may exist within the dual system of nursing or midwifery education and service provision for an emphasis on one over the other. They see the documents they have produced as going some way to address this, often acknowledging the shared expertise necessary in the compilation. They do not see themselves as practice experts and acknowledge the need for clinicians to be fully involved in curriculum development, recognising however, that increasingly this is becoming a resource issue.

How reliable are current assessment strategies from the clinical practitioner perspective?

**Practitioner:** *'In a lot of cases probably not very accurate at all really because you don't, although they are your, your students – some preceptors don't actually work with their student more than one or two shifts. So then you have to rely on other members of staff, their perceptions of the student.'*

**Interviewer:** *'But a lot of the other members of staff are untrained.'*

**P:** *'Mm. So you try and OK so you, they give you input and you think yeah fair enough that's a real point of view. You can pick holes in a lot of it because they are untrained and think yeah but OK um and you try and obviously you try and get the majority of your opinions from the trained staff but there are times when you know it's very difficult and you're thinking from what I've worked with this student I haven't had a problem. And you hope that your colleagues if they have had a problem will come to you and say your student's done this or your student's doing this could you sort it out but human nature being what it is people quite*

*often won't do that. So you do get the situations where we've had situations where we have had students who've got to their 3rd year who really are quite appalling in their practice but have been through several wards and got glowing reports because its easier to give a student a report and move them on, 'cos you've only got them for eight weeks um. We've got a bit of a name, a name for ourselves for sort of clamping down on students if, if we've got a problem, we will get the school in. And we will say to the assessees this isn't acceptable for what you're doing. At your level you should be able to do a, b and c and you're not.'* (Senior ward manager)

Variations upon this theme can be heard in most of the interviews with assessors, lecturers and assessees. These remarks are not a criticism of colleagues, nor an allegation of incompetence, but comment on the conditions under which assessment is carried out (see Chapter 2). In order to cope with assessments this clinician will do one to one-and-a-half hours' unpaid overtime. Apparently without intending criticism, she notes that many of her qualified colleagues are not willing to do this. Indeed:

*'I have had no course and I think … I was speaking to a colleague the other day about students and she said they had one, I think it was one course which was two days which was actually a year and a half before the first lot of diploma nurses even landed on the ward. There was no updating from then on and like she said you know yes you go to the study day, you take a certain amount in. A year and a half down the road "yes and what did they say about these books?" And that's it. Then you just "off you go chaps" … It's like the blind leading the blind in some cases which uh isn't the best way to educate somebody or assess somebody.'*
(Diploma programme assessor)

There is then the task of using assessment documentation which may be a substantial booklet. The booklet is 'a nightmare' for some, due to the language in which it is written. This assessor explains that she is doing a programme that has introduced her to some of the language but:

*'Even if you know how um sort of academic language is worded you know you're sitting there reading these things and think "what does that mean?" 'Cos some of the things about philosophy you think it's very, very confusing wording and you're trying to sit there and think now how do I apply that to what they've done today? They've wiped somebody's bottom. How do you bring philosophy into, you know, it isn't … it's not easy. None of them are easy. And I find quite a lot of sections are repetitive … which then brings the frustration out into you. You're just sitting there thinking I've just written about this three pages ago why am I now rehashing it 'cos you've just re-worded it very slightly differently … They're very wordy documents. Um and even the students say these things are a nightmare to read. Even they read them and say "I don't know what this is supposed to be, can you tell me what I'm supposed to be writing here?" Which um I don't think is particularly brilliant [laughs].'* (Degree programme assessor)

What seems obvious to a lecturer, seems foreign to a practitioner. There are two cultures each defining what is appropriate. There is the apparent disjunction between 'wiping somebody's bottom' and attempting to apply philosophy to the situation. It is not an issue of less documentation but rather of its fitness for purpose. In elaborating upon this, the same nurse made a contrast with her own more traditional training:

*'No I mean I'm not averse to documentation at all um. Well we used the stupid tick-box things which were equally as bad because they didn't really say anything, they were just a, b and c or no, sort of thing.'*

These tick boxes were then contrasted with the present format which was divided into sections with comments:

> *'I don't mind writing the comments and I don't mind the sections but I think that they need to be relooked at and see if they can condense them into more concise language and not repeat themselves.'*

Its real merit for her is that the documentation provides a framework which is particularly useful when working with difficult assessees:

> *'... but you do get the students who [say] "Oh I dunno" [what they want to do] and it's very difficult if you don't have a framework to sort of bring them out and say ...'*

The framework not only provides a way of working with assessees it also begins to define what counts as professional work; it orients learners to what they may become. At issue is as much the nature of the role as the quality of the assessee's work. Assessment becomes a subtle arena for contesting the nature of the professional role. There are two competing agendas at work. For example, the issue of defining the role of the professional at the centre of the assessment process came out in the following sequence talking about problematic assessees:

> *'Sometimes it's the very confident ones because they're too confident. They're doing things way above their um what they should be doing, even way above what a trained nurse would be doing some of them have tried to do, "I don't do that as a trained nurse luv, you're not doing it as a student" [laughs]. You know. "But I, I'm going to have a degree." "You may be" you know, "but that's not your role, you may have a degree to back up your knowledge but what you're trying to do is not within the remit of the nursing profession as we are at the moment. You're getting into the territory of the doctor or whatever. You wanna do that you need to go and do your medical degree."'* (Degree programme assessor)

The dispute, in her mind, centred on the aspirations of the degree assessees, particularly male assessees:

> *'Some of them seem to think they're not ever going to have to touch a patient at all. And that they're going to automatically qualify and go into intensive care or um CCU or theatres or something and well yes the majority will but there isn't a job for everybody in those areas you know.'*

She saw a difference between diploma and degree assessees regarding what they think they should be doing. In her view the difference was the move towards the specialist bordering on medical. Despite her reservations regarding the attitudes and ambitions of certain assessees she had met, she was in favour of extended roles:

> *'The level they're being taught to I would imagine it would encourage you to extend your role obviously because you're being taught to analyse things much more, um, use much more varied knowledge and a more in depth knowledge to back up your actions. But you're still a student. Even though you're doing the degree you're still a student and although you have great knowledge there's still a lot that you learn from experiential learning, actually hands on you know, when patients don't come out of text books and I think they, some of them seem to still think that "Well I know all there is to know about this condition and this patient's going to behave like that" and they do, they come unstuck, you know you can see them and you say "No you're not".'*

These remarks bring levels and the processes of doing, knowing and action, into relationship.

## 3.3 How assessment is done now: schedules and other documentation

In general terms, interviews with assessors and assessees and attendance at assessors' preparation and updating sessions confirm several areas of concern which they see as problems with the assessment documentation. The most common criticism is that the documentation is bulky, lengthy and time-consuming to complete. We should consider what they identify as the reasons for this and the difficulties it may engender.

Many feel that the documents attempt to do too much – that a single document is often designed for programmes with a variety of branch outcomes, which must be applicable in every clinical environment encountered by assessees throughout the programme. This results in a document which, in any situation, has many sections that do not apply, adding to the overall bulk and representing something which, with the increasing awareness of cost-efficiency, is seen as a profligate use of resources.

Others feel that the attempt to facilitate their use in every possible allocation renders documents general (or generic) to the point where they are unable to convey any valuable information. Their completion is seen as a ritualistic requirement. Documents in this category are often employed primarily to provide the host organisation with protection against possible litigation. Furthermore, their satisfactory completion furnishes the educational institution with proof that an assessee has fulfilled the necessary time component in that environment.

In some schemes, the implied necessity to break down every nursing activity into its constituent components and list their various applications is seen to be repeated for the same skill in every practical allocation. Assessors are understandably critical of a system which they find cumbersome and time-consuming but does not seem to reflect a sense of progress from one allocation to the next.

There is disagreement about whether the introduction of an ongoing assessment document, which would accompany the assessee from one placement to the next, would be more useful.

Advocates of this approach suggest the benefits would include a continuous record accessible to each assessor, enabling them and the assessee to gauge the acquisition and development of skill, address any learning deficits and concentrate upon those areas. It would reduce repetition (both of experience and completion of assessment records) and is seen by some as providing a better instrument to chart progress. Current documentation is inflexible in this respect, with little opportunity for acknowledging relevant prior knowledge and experience. It often carries an apparent assumption that all assessees attain comparable levels of achievement at approximately the same point, and have no mechanism by which to fast-track an assessee with extensive previous experience (such as a trained nanny who becomes a children's nurse) or outstanding ability.

Arguments against a continuous, open-record approach to assessment include the fear that this could be instrumental in forming and perpetuating bias. This could be a negative effect where an assessee's early performance was felt to be unsatisfactory, or a positive 'halo effect' from exceptional achievement early in a programme.

Other factors contributing to the length of some of the documents reflect an attempt to make them more accessible and their completion easier to understand. It is hoped that encouraging assessor-compliance will render the actual assessment more meaningful, increase the consistency of its application across various clinical environments and contribute to its reliability. Methods by which this is attempted include specific instructions to assessors which form an integral part of the document.

By contrast there are schemes where a common format for the assessment of theory and practice is assumed but few guidelines provided. Some documents indicate the format to

be adopted, relating a broad band or range of marks to performance at a particular level of expertise and knowledge. This may be copied identically from a marking scheme for written assignments. Given the constraints upon their time, assessors are often unable to employ the document to question and explore practice with assessees.

Some schemes are designed to include evidence of reflection as an integral part of the assessment of practice. This may involve the submission of portfolio material (Chapter 7) or the presentation of additional recorded evidence. Or it may be incorporated into the structure of a single practice assessment document, adding significantly to its bulk and complexity. Assessors report difficulty in knowing the type of material to include and how to gauge the extent and possible application of any reflection which may have occurred. They may resort to using the assessees to translate what they (the assessors) see as educational jargon, while assessees themselves expect assessors to be able to interpret aspects of the assessment process for them. Assessment and curriculum teams may spend many hours attempting to eliminate any possible confusion among practitioners, but there are sufficient examples from practice where both assessors and assessees are critical of the wording to give credence to the accusation that, in places, documents remain unnecessarily complicated and incomprehensible.

Where the clinical link relationship is well developed, the link teacher is able to offer help and guidance to assessors and assessees on completing the documentary evidence of reflection, and in some instances to participate in the reflective process with them (see also Chapter 7 on portfolio evidence).

## 3.4 Assessing the realities of doing, knowing and action

In a theoretical memo commenting upon the discussions that developed during the final feedback session carried out with staff at one trust/educational institution partnership, a member of the research team made some initial distinctions:

> *'We need to bear in mind a distinction between "doing" and "action", where doing refers to the frequently heard statement by nurses and assessee nurses that they want to do the job and not waste time or be drawn away from the essential job of caring, of being hands on. Action, however, might best be reserved for the kind of doing which has a longer time scale and refers to a choice between alternative courses of action and hence is embedded in reflective practice in the critical sense of the term.*
>
> *The business of professional life might too easily bring about a slide from 'action' to just 'doing' and worse, to 'making do' (compromising).'*
>
> (Researcher's theoretical memo)

Synthesising these early remarks with discussions in earlier chapters, what emerges is the following tentative attempt at a theory of levels that fits with the realities of practice (Figure 3.1). (A second, complementary theory is developed in Chapter 6 – especially Sections 6.5.1 and 6.5.2, where the concept of broadening perspective is explored. The model of levels in the current chapter is extended in Chapter 8.)

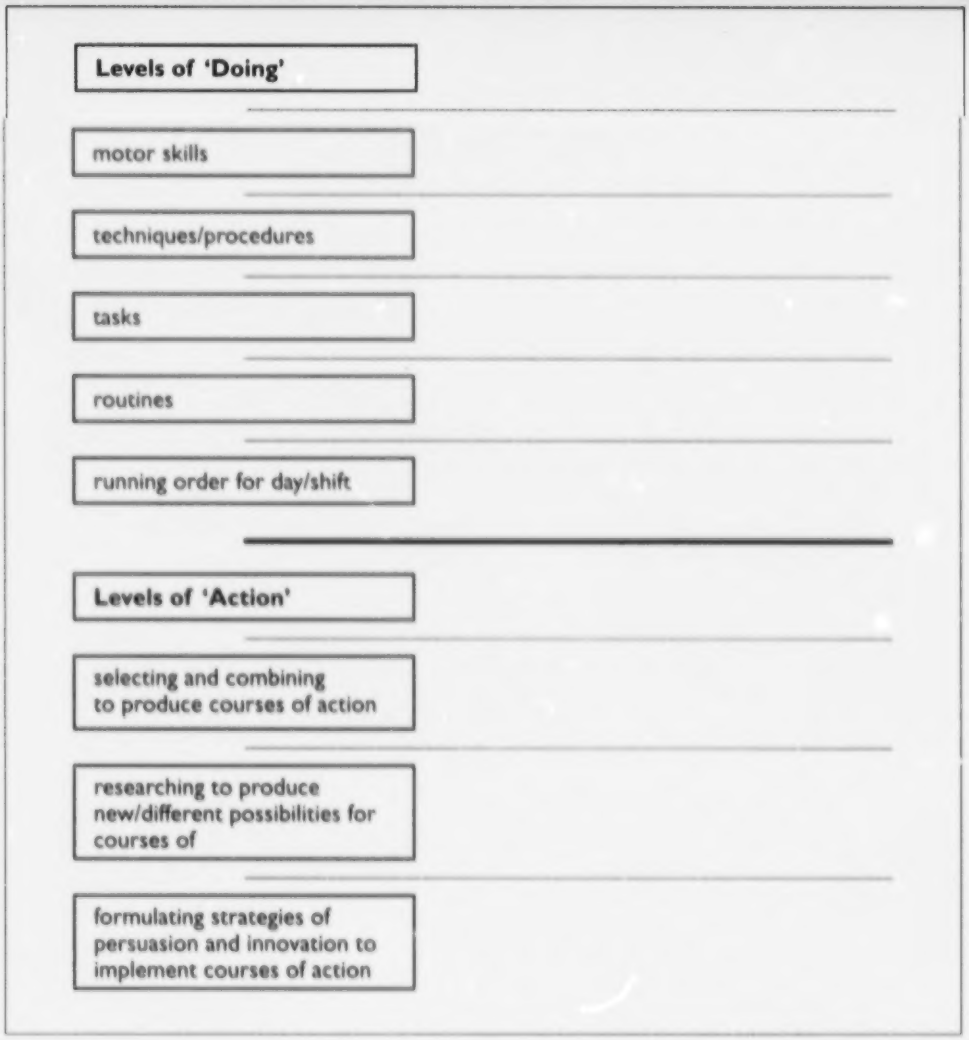
Levels of 'Doing'
motor skills
techniques/procedures
tasks
routines
running order for day/shift
Levels of 'Action'
selecting and combining to produce courses of action
researching to produce new/different possibilities for courses of
formulating strategies of persuasion and innovation to implement courses of action

Figure 3.1: A model of assessment

To be assessed at the level of doing, a series of motor skills must be mastered if a procedure or technique is to be accomplished safely; this combination of motor skills may then comprise a given technique or procedure. A series of techniques or procedures may then comprise a particular task which in turn may combine with other tasks to form a routine which in turn structures the running order of the day/shift. This level seems to fit well with what professionals describe as the realities of delivering care whether basic, advanced or specialised. Where they criticise both training and assessment it is at these levels of doing for not attending to the nature of the job (Chapter 8).

The level of action initially refers to the need for a professional to be able to do much more than simply follow a routine. The assessment task at this level is somewhat different; judgement is required as the professional draws selectively upon experience and combines knowledge, skills, techniques and so on to formulate appropriate courses of action. This is where experience and judgement count leading to such statements as: *'although you have great knowledge there's still a lot that you learn from experiential learning, actually hands-on you know, when patients don't come out of text books'.*

Although the model as crudely conceived in Figure 3.1 suggests a linear progression, it becomes clear that this is not the case. It appears linear only if time is drawn vertically. Technically, the levels are best viewed synchronically (see Chapters 6 and 9). When acting in real time an actor chooses when it is appropriate simply to do as one is told, to follow a routine

or to challenge a routine. These choices are not a matter of levels but of appropriateness to a situation. The analogy is with that of a language user – the speaker has all the words (lexicon) of a given language available together with the rules of selection and combination (grammatical code). What use an individual makes of all the possible resources depends upon knowledge, purpose and rhetorical skill. At every stage in an assessee's development there will be combinations of knowledge, skill and purpose to take into account when making assessments which will vary in sophistication no matter whether they are in their first or third year. The same multilayered pattern seems to persist even in highly experienced individuals who, for example, find out for the first time during advanced programmes the rationale for carrying out procedures they have carried out routinely for years. Higher levels of action, which may as much reside with the assessee as with the assessor, take on the quality of applied research where knowledge itself is under scrutiny.

Becoming a functioning member of the team is a major aspiration of assessees. It means learning to know one's place in the real running order of the day, not simply its ideal format. Indeed, it seems clear from assessee interviews that failing to be accepted in this way courts failure in placement assessment . More problematically, getting on with the job, whether as an assessee, lecturer or nurse, generates short-termism. Satisfaction is about completing the job in hand, and the job is defined around a narrow focus of concerns which tend to have short deadlines. Prioritisation is about juggling short-term deadlines. This effectively postpones long-term reflection indefinitely. These elements help to define the work required to run the system, which in turn defines the conscious field of observation for the worker, in effect binding the self-reflexivity of the worker to the objects of concern in the workplace. Thus the identity of the worker is 'produced' as an effect of the work required to run the system.

In summary, this work can be itemised into:

- a typical running order for a day narrative examples of which were given by ward managers
- the work required to compose the real running order of the day from:
  - typical disturbances of the running order
  - unusual occurrences that may not be foreseeable but which demand immediate responses and hence a re-ordering of priorities and running orders.

It would seem that assessees must not present themselves as a disturbance to the running order. Indeed, they must become a functioning part which contributes to the running order, and be able to respond at least to the typical disturbances. This may lead to unsafe practice where, for example, an unqualified assessee is left in charge of situations requiring knowledge and skill beyond their experience, or even being 'taught' by a care worker rather than a nurse.

The way in which the real is composed in relation to the ideal, running order becomes the master rule for justifying actions and decisions. The value system supporting the principle of maintaining the running order is learnt through rubbing up against the practices, beliefs and key metaphors of the prevailing occupational culture carried, used and transmitted by the staff. Why do 'x'? Because it works, i.e., it maintains the underlying running order of which a given day's actual practice is but an understandable variant due to responses necessitated by usual or unusual disruptions to that order. The experienced member of staff has 'seen it all' and is rarely surprised by anything – even innovations. What they really want is to be left in peace to consolidate – to get back to the familiar running order or at least to recover a sense of a familiar running order.

Of course the ideals of running order and familiarity are currently lacking in some way since there is always a sense of pressure, a lack of resources, particularly time. The professional is constructed through this sense of lack. Because there is always some lack there must be some

expediency. Thus the worker is always in danger of being co-opted into covering up an organisation's failures to provide adequate resources, mechanisms, procedures, practices and visions/philosophies.

## 3.5 The symbolic meaning of levels

Given that valid assessment must be sensitive to both enacted and *symbolic* meanings, what range of symbolic meanings surround the attempt to position practice in relation to academic levels? Entailed within this question are a further set of questions.

- What do lecturers and mentors see as the purpose of attributing levels to practice?
- What do they understand by particular constructs of academic level?
- How do these understandings relate to practice concepts such as safe, good, excellent and outstanding?

This chapter considers these issues from the point of view expressed by assessors in interviews. In Chapters 6, 8, 9 and 10 they are examined again in the light of evidence from *direct observation* of both practice and assessment.

While a number of nursing and midwifery departments are seeking to identify practitioner ability in terms of levels of practice as well as theory, others resist such a move, assessing practice only in relation to a competent/incompetent (pass/fail) distinction. Levels assessment has a different symbolic meaning for each group. For those who believe it is worthwhile, a considerable amount of time and effort is invested in creating complex and detailed documentation and guidelines on its use, partly because they wish to get it right but also to convince others who see a different symbolic meaning in the activity.

Ostensibly, the aim in seeking to grade levels of practice is to ensure that quality in practice is taken as fully into account as academic quality when educational institutions award professional qualifications. To achieve this aim the criteria for differentiating levels of practice must focus on commonly-held perceptions of practice at given levels. The research evidence shows almost no agreement about the criteria for any level of practice beyond threshold' or 'basic safe practice'. Or at least, there are no sharable criteria which apply to observable differences in practice. Policy-makers, curriculum planners and assessors are unequivocal about the symbolic meaning of levels, but uncertain about what the criteria are for affirming achievement. What, then, are these meanings?

As part of higher education, nursing and midwifery educators perceive and experience levels as an issue of quality assurance; the differences between diploma, graduate and post-graduate levels of intellectual activity for their colleagues in other departments are the same for them. Symbolically, assessing practice level represents an alignment between nursing and midwifery and the rest of higher education to protect university standards. The symbolic meaning to nursing and midwifery departments as providers of practice-based programmes for professionals is somewhat different. This time, the assessment of practice is a means for safeguarding the status of the practice component in programmes. Levels of practice are assessed in part to establish the seriousness with which nurse and midwife educators regard the non-academic. They make it possible for the excellent practitioner to be valued equally with the outstanding academic. For most purchasers of education, levels have a different symbolic meaning again; they represent human resource management. They mean the chance to regulate the flow of advanced practitioners in relation to basic grade practitioners and managers in relation to clinical staff. The number of basic grade practitioners and care assistants a trust employs is directly related to how many advanced level staff it can secure, as one interviewee says, pointing out very eloquently what the implications for nursing quality could be:

> *'I guess there are huge dilemmas at the moment, there is this declining workforce of registered nurses and I can understand that at the same time*

*there are growing numbers of health care assistants who are actually giving care which nurses in a sense have thrown away – it's a bit like the "dirty work" of nursing – there's a need for reduction in doctors' hours so nurses are queuing up saying "yes, yes, we'll do it" and the same time they're giving away the care that's now being taken over by health care assistants.'* (NHS trust manager)

### 3.5.1 Levels assessment as a negotiation

A simplistic acceptance of the viability of using levels criteria to differentiate practice begs at least three questions.

- Are criteria for intellectual level commensurate with those for levels of practice, where it is necessary to assess both knowledge and its use?
- What is evidence of threshold, further and advanced levels?
- What constitutes evidence of movement from one level of practice?

Assessment is inevitably a negotiation about what is being assessed. It takes place during the doing of assessment and in document construction. Interviewees make it clear that, in doing assessment, they feel subject to pressure from several directions. The extent to which they can negotiate a coherent position in response substantially affects the trustworthiness of their assessment.

Three different voices, each representing a pressure to take a position, are apparent in the following statement from a lecturer:

*'... get quite frequent feedback from the work I do as a teacher ... quite frequently [they say] they're [the descriptive criteria] too broad ... we want something more specific ... [inaudible]. And, you know, you try to be civil ... I feel rather exasperated when I hear that sort of thing because I know how long and hard we sweated to try and choose something that the ENB, for example, wouldn't say, you know, that is not comparable with that ... and you've got to make them a bit more equally balanced.'*
(Degree programme lecturer)

In this statement the voice of the clinical practitioner calls for clarity (elsewhere there is a demand for less jargon) and the voice of the validator pressing for precision and balance. The lecturer's own voice pleads for recognition of the hard work invested in the construction of an assessment schedule to meet the requirements of mentors and regulators and still perform a useful educational function. The statement reveals the work necessary to reconcile the different voices and the positions they represent.

In working with assessment materials, lecturers and assessors are obliged to take a position; these are often contradictory. Lecturers may use academic levels descriptors to assess practice but be uneasy about doing so. Assessors may grade practice but profess difficulty in distinguishing a Level 2 practitioner from a Level 3 one, or a Level 3 practitioner from one practising at Level 4. And practitioners and academics are divided into those who say they can recognise a Level 3 assessee when they see one and those who want more precise criteria and levels descriptors.

### 3.5.2 Experiential levels and practice as being

As this research is concerned with the assessment of practice, it focuses on the criteria used to attribute levels to practice (where practice is actually a *set* of practices). There are some broad differences in expectation about what should count. Lecturers, usually the majority membership of curriculum and assessment planning groups, are most often concerned about ability to do, understand and make principles explicit. They are interested in practical competence, theoretical knowledge and *understanding*. This requires a vast amount of written evidence:

*'Students on pre-registration students' have a portfolio and handbook that is available to the assessor. They take them with them to all placements. Our unit is small and there is a lot of rotation of staff through the unit. Assessors are likely to have met the student in previous placements. Not as diverse as in nursing. The student would also have with them written practice outcomes that would have to be achieved at some point in the programme. These outcomes would meet the EC Directives for Midwifery training and Rule 33 of the Midwives Rules. The Portfolio provides the evidence of how the student has achieved the learning outcomes. Also gives quite elaborated detail of what has got to be achieved by the student.'*
(Lecturer)

The assessor group, on the other hand, tend to start with a view of what a *'normal'* practitioner *'is'*. They do not talk about *becoming* a practitioner but about *being* one. To *be* a 'good' practitioner one must be *'willing to have a go'*, *'a good listener'*, *'confident'*, *'calm under pressure'* and above all *'caring'*. It is possible to satisfy written criteria, even be an expert, but still not be a good practitioner.

*'Because the practice assessment is so woolly … they [assessees] can achieve their practice assessment but not be a very astute or 'good' nurse.'* (Assessor)

*'With all these specialist nurses … erm I think a few are incredibly valuable … it's almost as if they'd do anything rather than put an arm round a patient which could be the most significant event in somebody's stay in hospital.'* (Post-registration student)

Assessors are short of time and constantly under pressure in the hurly-burly of the clinical environment. Unless guided by detailed documentation on how to differentiate them, they treat all assessees the same. In the absence of documentation identifying differences in practice outcome, many assessors evaluate diploma, degree and post-graduate assessees in terms of whether they *'are'* or *'are not'* nurses.

For these same assessors, and for some of their employers, being an 'excellent' assessee means being able to capitalise on personal qualities in difficult or highly specialised contexts. An excellent practitioner is *'a special person'* who is not only able to *be* a good practitioner but also has specialist knowledge and/or skills. The knowledge *per se* is not what makes them an advanced practitioner, these assessors believe, it is the fact that they can use it in context because of their personal qualities.

*'There cannot be a route to professional development in my view unless there is an inherent motivation to be different personally, if we accept the definition of what learning is … it's about making some kind of permanent change … you have to acknowledge that in that process there will be some kind of personal development and if people think learning is about acquiring "chunks" then my question to them would be "then why would we invest money if it isn't going to make any difference?"'*
(NHS trust manager)

For many people, an advanced level practitioner (often one enrolled on a post registration programme) is one who has developed confidence and awareness:

*'I'm hoping that [assessee] will become more comfortable in your role really, the chosen role that you're doing and accept and acknowledge your moving on and your change. It is difficult and I suppose from where I'm at … it sounds very presumptuous to say growth, but acceptance and growth and enjoyment really in a new role where there's [previously] been a lot of query and reticence and lack of confidence I think.'*
(Assessor talking to her post-registration assessee)

Practitioners working alongside the assessee are less concerned with making connections between types of knowledge and levels of practice than with how much an assessee behaves *'like a nurse'*. They are inclined to downplay fine discrimination and look for the assessee's 'nurseness' or 'midwifeness' in particular situations and with specific people. This group of assessors share information about the way an assessee 'is' as a practitioner, they talk about what they are like rather than what they can do. Significantly, this information is passed on in talk, through comments and anecdotes rather than detailed written documents.

### 3.5.3 Joint assessor/lecturer definitions of level

Collaboratively produced assessment documentation recognises the importance practitioners attach to being a nurse or midwife. The characteristics of what this means are included as core criteria for professional practice, acknowledging the centrality of personal qualities:

- *'presents self in manner which promotes a positive image of nursing*
- *reliable*
- *honest*
- *attendant*
- *works collaboratively with colleagues from own/other professions.'*
  (Assessment document)

It also recognises that a person with these key characteristics can develop by being responsive to changing and unexpected contexts:

- *'sensitive to the unique complexity of different situations [reflect on critical incident]*
- *transfers knowledge and understanding to present and new situations of practice.'* (Assessment document)

Even the set of generic key characteristics and learning outcomes which accompany the core criteria above and show development in terms of progression from Level 1 to Masters level are rooted in observable (inter)personal characteristics which are core aspects of being a nurse or midwife. In relation to bullet point five in the core criteria (focused specifically through team-working) outcome criteria are given as:

> *'**Level 1** – use interpersonal skills effectively to relate to team members, clients and carers*
>
> ***Level 2** – implement effective interpersonal skills in a variety of situations that involve other team members, clients and carers*
>
> ***Level 3** – in the context of complex problem-solving, reflect and evaluate appropriate interpersonal strategies used with other team members, clients and carers that indicate good working relationships*
>
> ***Level M** – in the context of complex problem-solving situation, implement strategies and critically review the outcomes of a good working relationship, used with other team members, clients and carers.'*
> (Degree programme assessment document)

The movement is from 'being' in relatively uncomplicated situations to 'being' in complex and potentially problematic situations. The significant point is that development is defined as ability to respond to significant variations in familiar contexts and to unexpected features of entirely new contexts. This requires competence in recognising the salient features of a context, being responsive to client's personal needs and being alert to changing local and national health care agendas. All of these are appropriate skills for the purpose of hands-on care and involve observable behaviour; greater facility at and speed in prioritising action, ability to

do x, y, or z across an ever-widening range of environments. This conception of levels is one of development *within* hands-on nursing or midwifery not *beyond* it into management, teaching, research or specialist practice, but at the same time it places significant emphasis on the intellectual aspect of nursing/midwifery.

### 3.5.4 The 'deskilling of practitioners' problem

The situation is, then, that we have practitioner-assessors and lecturer-assessors, in two broad groups, looking at practice from different perspectives (although significant minorities within each group do not fall easily into a camp). This makes both sides uneasy; they wish to collaborate, so they are forever checking whether they have got it right.

Neither side is expert any longer, both are deskilled. This situation could provide the nexus for educational growth and increased mutual understanding of the relationship between theory-practice. Open and transparent discussion which acknowledges mutual uncertainty and even confusion, offers the best potential for developing a valid profile of what a specific practice level would look like. Unfortunately, according to interviewees, where such discussions do occur, the motivation is often fear.

> *'I think the other reason for it was the care plans because I think a lot of health authorities then, trusts since, got very worried about the documentation so in a lot of places because they didn't have the time to allow the staff to develop their own approach. I mean I was involved a long time back, with working with ward staff to talk to them about the nursing practice … what would have been ideal would have been start with a blank sheet of paper and get the staff to actually develop themselves. But of course, certainly with the health authority I was working with, and I think probably nationally, the managers didn't a) feel that they had the time and b) didn't feel they couldn't take the risk of the hiatus of maybe 18 months to two years while people were properly prepared and they had no common legal record if you like, and I think this was the fear.'* (Manager)

Many practitioners defer to the academic expert, look for better-defined academic criteria and lack confidence in the face of them.

> *'Are we doing it [assessment] right? We don't know 'cause we don't get the feedback.'* (Assessor)

Many assessors respond to the suggestion that practice could be graded by requesting guidance on how to recognise the difference between (say) diploma and undergraduate assessees, or Level 2 and Level 3 assessees. For them the usability of assessment documentation – its non-technical language, conciseness and comprehensiveness – is important.

> *'For the sake of simplicity both of these tools, the long and the short one, have to be useable in a variety of areas. So, you're forever trying to sort of choose one of them which means something to everyone who's ever going to need it. And, see if you do that you lay yourself open to the accusation that you've not been big [comprehensive] enough.'* (Lecturer)

> *'We do have a very elaborate, well a relatively elaborate set of tools. Now when they do quite short placements, they don't use that. They use a sheet of A4, a simplified version which is just literally an A4. And partly that's in response to the sort of people in the area who [inaudible] nursery.'* (Lecturer)

Consequently, on the one hand there is a (not necessarily successful) drive for rigorous criteria to identify levels of understanding and on the other a perception that it's not worthwhile trying to identify levels beyond what would count as common sense.

## 3.6 Assessment for the future: making challenges

Implicit in the introduction of diploma and graduate education was a challenge to the nature of the caring professional. Is there: (1) a traditional core aspect to nursing and midwifery which is common to all practitioners; or (2) a change in their core self-definitions (and hence releasing some tasks and activities as it adopts others) which leads to a repositioning of the profession in relation to others; or (3) a repackaging of the professions into an amalgam of specialisms, functions and concerns which have increasingly little commonality with each other? Thus in the latter cases groups of core aspects might be 'abc', 'bcd', 'cde' and 'def'. Core aspects 'def' have nothing in common with 'abc', yet arguably they may both appear in the category composed of the entire sequence. Each group may be defined as constituting a particular branch of the total sequence or more loosely, the total collection; or, certain clusters may have more in common than others and produce relatively independent divisions within the total profession, say community as distinct from hospital; or mental health as distinct from physical health. The different configurations would lead to different implications for teaching and assessment.

Rather than some static definition of a baseline, as may have been the case before the introduction of pre-registration diploma education, baseline(s) may be both shifting and multiple. One way of conceiving such a baseline for a given profession or specialism would be that baselines are circumstance-specific and there are as many baselines as circumstances and these change as circumstances change. This would mean that a critical advantage of the research-based reflective practitioner is that they are not restricted to one baseline (we always do this this way) but can determine new ones to address their clients' needs as they change over time. This implies that a baseline cannot be imposed upon a given clinical area but must be drawn from it through a study of current circumstances. Impositional forms of curriculum and assessment therefore would only have a hit and miss relation to the real circumstances of the clinical area. This implies that assessing the realities of work should be a critical function of mentors, assessees, education staff and clinicians generally if baselines are to be relevant.

Does an assessment document reveal its principles in such a way that the practice circumstances are assessed in terms of how care is accomplished in real terms? Only by knowing this could one know whether the assessee is making appropriate judgements about how to act within given circumstances.

## 3.7 What is being assessed in practice and how are the levels determined?

This research has shown a variety of interpretation of assessment in practice, from the performance of an isolated skill to a complex interplay of knowledge, intuition, technique and application. These assessments vary from artificially designed or stage-managed simulations using dummies or models to real-life performance of procedures and techniques. There is evidence too that frequently what is being assessed is the ability to reflect upon and analyse action, and to provide a written account of this.

The problem for educationalists in establishing the curriculum is determining how to assess the level at which these more complex skills of reflection, analysis and synthesis are being performed, and how to translate this into a workable document for assessees and assessors. At this basic level it is a problem of measurement and the difficulty of deriving an interpretation of levels which is applicable to a simple psychomotor skill and the complex combination of skills and problem-solving necessary, for example in the prioritisation of care.

One way this has been addressed by some institutions is in the attribution of academic levels to practice-performance; applying established criteria for the assessment of theory to the assessment of practice. Schemes encountered during the project included those where practice performance is rated first, second or third level corresponding with the appropriate academic level and year of study; some of these schemes limited the acquisition of selected practice elements

to the designated year by level. Extension of the concept sees an enhancement of undergraduate skills at post-registration level to provide the practice component of honours degree programmes and the development of a corresponding skills-base for emerging Masters programmes.

Another commonly-used method to apply the same criteria to the assessment of theory and practice is where a grade or percentage mark is ascribed. The rationale for either of these approaches appears to be the desire to create practice assessment which will be applied consistently, compatible with the method by which theory is assessed and will provide a measure of reliability and validity. In every variation encountered of these approaches, common problems have occurred. Examples from practice show the difficulty assessors and teachers may have in agreeing a level of performance commensurate with an academic level. Where this is effected, the problem remains in ensuring that assessees are exposed to the appropriate level of practice experience for their stage of study. While practical placements occur in the real world of care-delivery, it is impossible to standardise assessees' experiences. The range and levels of skill involved will depend upon diverse factors: patient population, resource intensity and the dynamics within the regimen of care.

Equally, no two assessees will arrive in a clinical environment with identical prior experience; each individual will have accrued a different set of skills and aptitudes and at different levels of efficiency. Even the skill base for one assessee is unlikely to be consistent across the entire repertoire. In an example from practice, a child branch assessee was judged by the assessor as demonstrating a calming, reassuring approach to her patients but lacked the communication skills necessary to support and inform their parents. A skill which may be competently practised by a practitioner in one situation may not achieve a commensurate level of performance in different circumstances. For example, a post-registration degree assessee undertaking an ITU programme was found to be capable of prioritising care for a ventilated patient until he experienced problems with the patency of the tracheostomy tubing. At this point, the practitioner's level of performance fell. Problems here for assessors and those responsible for the curriculum involve the frequency or finality of an assessment. Even where a system of continuous assessment prevails, there needs to be some clear guidance as to when and how frequently any practice element is assessed, and if this is only to occur once, what measures are in place to ensure the maintenance of that ability.

Assessors are often uncertain whether the assessment is to be used as a mechanism to chart progression through an entire educational programme or through that specific allocation, and experience difficulty in knowing how much relevance to attach to assessees' prior knowledge and abilities. Some feel that a useful distinction might be made between an assessee's level of ability at the point of assessment and evidence of improvement during an allocation. Those who attach the greatest significance to improvement acknowledge the temptation to make a more favourable assessment in these circumstances, while others question the value of repeated assessments in areas where assessees already have demonstrated competence, as a result of prior experiences. In an example from practice, an assessor had two child branch assessees. One had previously been employed as a nanny, and showed expertise in handling children and communicating with them beyond that normally found at this stage in her education. The second had been ill at ease at the start of her allocation, but her handling and communication skills increased considerably. The assessor realised that she awarded a higher mark to both assessees than she would to one who had commenced the allocation *and* completed it at the level attained by the improver.

Other assessors worry that comparisons among assessees where one demonstrates exemplary skills, may result in an unfair assessment of those who would otherwise be judged satisfactory. Criteria on paper may appear definitive, but it may be difficult to remain objective where one assessee makes a strong contribution to the smooth running of the clinical team. Those who show ability are more likely to be afforded greater opportunities to participate, given greater responsibility and achieve more learning objectives than their peers.

Aspects of consistency, reliability and validity create problems for assessors, who question the appropriateness of assessment in this context. Many of those interviewed expressed curiosity as to the design structure of programmes; who determines what shall be assessed and at what level? The variety of programmes on offer and the extent to which the levels at which practice might be assessed in each of these, causes further concern, with assessors uncertain of the relationship between assessment criteria for different levels of experience and type of programme.

Potential transferability was also seen as an issue by assessors working in areas where educational provision is derived from more than one institution. They want to know to what extent interpretation of levels may be universal. For example: does competency at Level 2 mean the same on different post-registration programmes from the same institution, and does this correspond to Level 2 from the alternative institution. The attribution of credit accumulation and transfer (CATS) points to many programmes may have clarified this for some, but for practitioners outside the educational system, this may not be helpful, many expressing confusion over credits offered by the parent institution, on distance learning programmes and those encountered in journals.

Some assessors admitted having a problem in recognising the level of their own performance; they saw this as fluctuating between basic competence and a higher attainment and yet allowing for some element of uncertainty. They felt that insufficient attention is paid to a definition of levels and how to interpret the complexity of individual practice. In an example cited, the assessor felt that her own level of skill attainment may have coloured her assessments as she did not have great organisational ability. Consequently, she felt she probably assessed good organisational skills higher than she should.

## 3.8 Summary

All those involved in the assessment of practice testify to the difficulty in ensuring consistency across the spectrum of clinical placements, and recognise that an element of subjectivity is almost inevitable. Assessors' views will be coloured by their own experiences and education, and at best, any assessment regime can only impose a certain rigour over individual interpretation and response. Possibly as a result of this, most assessors and many teachers favour the attribution of grades rather than percentages to performance attainment. This is seen to negate the possibly biasing effects of one uncharacteristically good or poor performance. Percentage marking is seen as something teachers do whereas judgements of scale are more familiar in practitioners' work.

The preoccupation with levels, requiring the operation of a system which differentiates between degrees of achievement across an enormous range of clinical experience causes great anxiety for lecturers. Assessees too are often confused by a system which appears to require action to be validated by words and in which a disproportionate emphasis is given to one over the other according to the clinical or educational focus of their current experience.

## 4.1 Introduction

This chapter provides insight into the process of assessment at one remove from the practice environment. Chapter 6 focuses on assessment in the practice environment, while the theme of this chapter is taken up in Chapter 7 where the portfolio is looked at as a bridge between being present and at one remove from practice.

Assessors use three types of evidence, written, spoken and enacted (action in practice) to judge the quality of practice. Constructed forms (such as written comments entered on assessment schedules, reflective journal entries and critical reviews, together with preliminary, medial and summative placement discussions) and 'natural' forms (such as informal exchanges about patients and conversation about thoughts and feelings) have loomed large in assessment documentation (Phillips et al., 1994). Directly observable, unmediated forms of evidence have not, and seem to have been devalued because of that. This has lead many ordinary (by their own definition) practitioners to complain that *'the real skills of nursing/midwifery don't seem to count anymore'*.

What, then do we learn from observation of attempts to assess clinical competence close to practice but not actually in the practice environment?

## 4.2 Assessment by lecturers

It is a matter of chance whether assessees have much contact with their assessors. The extent of preparation for the role varies, so whether a student gets an assessment-aware assessor is also a matter of chance. Where lecturers know about this, they attempt to rectify the problem by trying to develop assessors' understanding of the assessment activity, or intervening directly in assessment. Those who take the first approach invest considerable time in building networks, creating confidence and encouraging an interchange of questions and answers. This requires frequent visits to practice areas, mostly in lecturers' own time as none is provided within the academic timetable.

> *'I don't have the capacity in my diary to be able to commit that volume of time.'* (Lecturer)

Some achieve the link by doing clinical shifts outside their working day, while others forego the opportunity to develop research. But where the building of trust through direct contact is the key purpose of a lecturer's visits, they have limited time to work with assessees and observe their practice. As one joint trust/educational institution assessor pointed out, the observation of assessees in practice by lecturers is as much a matter of chance as is their observation by practitioner-assessors.

> *'I sometimes come across the students … I do a clinical day once a month where I go and work on a ward for a variety of different reasons but one of the things I'm able to do … if there happen to be students there … is get a sense of what it is they're actually doing in clinical practice and whether they're making connections … It may be that I go to a clinical area that doesn't have students, it may be that the area I go to <u>does</u> have assessees in which case I take an opportunity, particularly for the group I've just taught, they're a group I've had quite a lot of sessions with now and when I see them in clinical practice you can talk through some of the stuff we've covered theoretically.'* (Trust/educational institution appointee)

This interviewee makes the point that when a lecturer is able to be with assessees the focus is likely to be more on what has been taught than observed. This is a systemic problem. Lecturers who teach at several campuses cannot build a good picture of the assessee, and fall back on their subject orientation when they meet in a placement.

> *'You could be lecturing at [campus] or [campus], all over the place. It was more the subject you were giving than how the group of students develop, and to me that's important. I don't have a particular group that is mine, I'm not a personal tutor.'* (Nurse teacher)

On the other hand, they are in a position to know what has been taught and thus what knowledge the assessee could be expected to draw on in making decisions about care.

> *'One of the things I'm able to do … is get a sense of what it is they're actually doing in clinical practice and whether they're making connections.'* (Midwife teacher)

The data suggest that joint-appointees and lecturer-practitioners are able to build trust with practice colleagues, and thus to discuss teaching and assessment informally with them. The data also indicate that this trust-building is perceived by lecturers to be more important than direct observation of practice. The emphasis is clearly on liaising with practitioners about assessment in general rather than on observing individual assessees' practice. The following lengthy extract makes this point very clearly.

> *'I do believe that clinical learning is extremely important but I'm not sure we've got the balance right in terms of, for example my senior nurse colleagues will say to me don't they get anything in school about pressure damage prevention. In the good old days, had I been the assistant director of nursing I would have bought into that myth and said "no, they don't seem to be 'cos they don't seem to know anything when they finish" but I know for a fact that I've just given a three-hour session on that and I know that they get it picked up in other areas when we deal with patient scenarios – there's always something in there about risk assessment, pressure damage etc. So it allows me to say to them "well, yes, they do get theoretical input in relation to that". And equally, the tutors from the other side may be saying, "don't the nurses in the trust ever document care, don't they ever try to make a connection between a model of nursing and how people organise their [patient] assessment data?" and I would be able to say to them, "well, yes they do but they don't perhaps, you know, in many areas they are not themselves fully aware of the rationale to then be able to make that explicit learning for the student, to, you know, to be able to say "what theoretical principles are we drawing on here, why do you think we are doing this?" rather than it to be day-to-day work that students do, actually capturing that learning for the assessee and saying "hey, yes you have learned something today. You've been able to apply the practice of what you do with the underpinning knowledge that's behind that" … I've really only come to that level of sophistication fairly recently myself so how on earth can we expect a lot of the registered nurses in clinical practice, who a significant chunk of them are fairly recently qualified themselves … to make the links for students going through … I think sometimes that creates the difficulties we have. And maybe that has a knock-on effect in how we actually assess learning. If we're not ourselves making explicit what learning is happening, then how do we know what to assess.'* (Lecturer)

From the data so far it appears that without some significant change in the organisation of lecturer time and the development of a critical mass of sufficiently qualified and competent assessors, the observation of practice by lecturers is not feasible. Other changes might help: for example, where educational institutions and trusts have agreed to placements longer than five weeks, lecturers have been able to work with assessees as well as staff. And where there are regular 'training and problem exchange' sessions for assessors there is less need to focus on the same issues during clinical visits (although if these sessions are voluntary, there is too little continuity for this particular benefit).

Regular lecturer visits to clinical areas do appear to serve an important purpose in establishing trust between the clinical and academic. They also facilitate the process of training for assessors and mentors. They do not usually, however, enable direct observation of individual practice.

## 4.3 Objective simulated clinical examinations

In an attempt to tackle the problem identified above, lecturers in a small number of educational institutions have directed their attention to the assessment of essential technical skills through the introduction of objective simulated clinical examinations (OSCEs). Observation of these proved highly informative, confirming the need to assess students directly as they put into practice their professional skills and demonstrating the difficulty of doing it reliably, even under controlled conditions.

The PANDA team visited two institutions using OSCEs and followed the assessment through preparation, participation and internal evaluation. In both cases the assessment took place in simulated clinical environments located in a university building. In one case assessees met 'patients' who were unfamiliar to them and in the other they encountered lecturers, some of whom they had met before, others they had not. In the first case the assessor was a different person from the patient, in the second they were one and the same. Despite these differences, assessees seem to have experienced the event in much the same way and had similar feelings of intense anxiety, despite the best efforts of their lecturers to put them at ease. How the assessment was done varied from one context to another, and even within the same context across time, raising doubts about the reliability of what has been alleged in some quarters to be highly reliable.

The following extracts from field-notes made whilst observing a day's OSCE assessment on two different occasions illustrate some of the differences between assessors and show how elements of the context varied. They also show how assessees felt about the event. (To preserve anonymity of the institution, precise details of the simulation are not included.)

> *'Station 3*
>
> *Before assessee starts, assessor gives instructions in series of clearly identified steps. Says 'off you go' and stands back to watch. While doing the simulation the assessee turns to assessor and explains nervously that he has had to do the blood pressure twice to get a norm. Assessor does not comment. Assessee later turns to assessor and makes explicit his reason for asking 'patient' for information. 'I asked Margaret for information about her swelling because I don't know her [history] very well'. Assessor still does not respond. After assessee has wiped trolley with sterile solution he places unopened pack of bandages on it. Realises and 'confesses'. Assessor acknowledges and allows assessee to remove package and 'put right' mistake. This involves placing sterile equipment on 'polluted' surface without re-cleaning it. At the end the assessor prompts assessee to clean up, and replace washing bowl, apron and gloves. Assessee passes.*

***Station 4***

*3 mins of complex instructions from assessor. Stands close by while assessee does injection, making written notes throughout. Assessor anticipates assessee's problem and advises her to ask patient where she would like injection. Patient asks, 'why am I being given this injection.?' Assessee doesn't know, turns to assessor for information. Assessor prompts assessee to say she doesn't know. Patient tries to point assessee in right direction. Assessee fails. (After assessee leaves patient says, 'I tried dragging it out of her')*

***Station 5***

*Assessor sets scene at beginning by giving details of patient's condition in simulation mode. Moves out of simulation mode by saying, 'the drugs are not real but the cupboard is. Gives feedback during assessment and explicitly links simulation task to particular piece of teaching on course. As she is writing on patient's record sheet assessee says, 'my hands are shaking so much – bloody hell I don't usually feel like this. So nervous she has difficulty writing in straight line. From then on patient goes out of way to put assessee at ease. Assessor does not wipe patient record sheet clean between simulations (other assessors on other stations do). Later, assessee reveals she has never used nebuliser before (activity she is now asked to do) but is encouraged to 'have a go". Assessee passes, getting positive feedback. 'I just wanted her to go away knowing she'd done OK, really.'*

***Scenario 1***

*Lecturer moves between patient role ('and how long are you going to record my temperature, nurse?'), facilitator role ('they take a bit of practice don't they?' 'have you got it?' 'take your time, you're doing fine') and personal role (considerable amount of playfulness around lecturer's actual age as assessee discovers she has high blood pressure). Assessee also moves out of simulation role — 'this chart's a lot more detailed than the one we had in our practice, do we have to fill it all in?', 'we were all in the lab last night and this morning practising everything'. Assessee shows thermometer reading to lecturer and asks 'is this OK?'; lecturer says, 'yeah, that's excellent'. Lecturer takes opportunity to teach assessee about allowing time for thermometer to dry after it's been dipped in alcohol. Lecturer encourages assessee when she finds difficulty getting b.p. right - tells her of own difficulties when assessee. Assessee passes.'*

(Researcher's field-notes 1)

Assessors provide different degrees of support for assessees. Some adopt an examiner role, some a facilitator role; others see the occasion as a teaching opportunity. Some vacillate between the three roles. Many, like the lecturer at Station 5 (who focuses on the drugs component of the three-part simulation) and the one in Scenario 2 overleaf (who causes her assessee to spend longer on the thermometer routine than other parts of her simulation) seem to see the occasion as a test of what has been taught and an opportunity to make last-minute, corrective input. Others, like the assessors at Station 3 and Station 4, stay in assessor role, leaving any teaching until after the simulation.

Assessor expectations about which mistakes can pass without immediate comment and correction seem to vary considerably. The same is true of their expectations about what amount of prompting, if any, is acceptable. All lecturers want assessees to do well but while some look to achieve this by making the assessment as fair and 'unpolluted by distraction' as possible, others try to help assessees by giving cues and prompts. Assessees who receive constant

correction from assessors during their simulation become increasingly nervous; those who are prompted, directly or indirectly, could be said to have an unfair advantage by comparison.

'Patient' responses are just as diverse. Some prompt their assessee to give them information and explain what they are doing, while others remain relatively passive.

Field-notes reveal considerable variation in the way assessment is carried out. Whether an assessee passes may depend on the assessor and the patient as much as their own skill and knowledge. Surprisingly perhaps, the variation is often as great between the assessments carried out by a single assessor over time. The following extracts record one assessor with two successive assessees.

> ***'Scenario 2: Assessee 1***
>
> *Lecturer, in role, asks assessee for i.d. before she will let her begin. Prompts assessee, still in role ('the other nurse said ...'). Taps her glass to remind assessee to check on whether she has had a hot drink before assessee takes temperature. Assessee cannot immediately locate pulse so lecturer places assessee's fingers in correct position. Offers assessee a clue about the likelihood of her blood pressure being unusually high ('first nurse took a long time because she had trouble with my blood pressure, so I had to get her to do it three times before she got it right'). Guides assessee to comment on complexion. Assessee begins nervously but increases in confidence after while. Suddenly, lecturer steps out of patient role and begins teaching assessee how to shake thermometer. Assessee's confidence appears to recede. Assessee passes.*
>
> ***Scenario 2: Assessee 2***
>
> *Lecturer does not ask this assessee for i.d. Is more obviously in assessor mode than with last assessee. Assessee comments on complexion and patient's weight but says she would think twice about commenting first time she met patient because of fear of offending her. Lecturer suggests she should comment. As assessee takes blood pressure, obviously experiencing some difficulty because she cannot believe the high b.p. she is hearing, she becomes uneasy. Lecturer, moving out of patient mode, asks her what systolic and diastolic mean and how she would recognise them. Assessee moves on to taking b.p. Notices cup and asks patient if she has had a hot drink recently. Then removes thermometer from case, dips it, wipes it and moves to put it in patient's mouth. Lecturer asks her to shake the thermometer. Assessee does so. Lecturer tells her to do it with more vigour, facing away from table. Assessee says, 'my fingers are so sweaty I'm afraid it's going to fly out of my grip'. Lecturer asks to be shown level. Assessee quizzed about need to shake mercury down. Assessee doesn't know. Lecturer explains that mercury will not fall back by itself. Session proceeds for twice as long as previous one. Assessee fails.'* (Researcher's field-notes 2)

One of the main purposes of OSCEs is to permit a large number of assessees to demonstrate their ability to use basic technical skills under exam conditions. Because of this, there are many simulations happening in a short time and assessors inevitably lose concentration or vary their approach to relieve the boredom of repetition. It is not surprising, therefore, that there will be a degree of intra-assessor unreliability. As in the scenario above, for example, the assessor may emphasise one part of the activity with one assessee and another with a second. If, as in this case, they are playing the patient role too, they may stay (playfully) in the role with an assessee who appears competent early on, thus encouraging that assessee. On the other hand, as the assessor in Scenario 2 does with the second assessee, they may signal that they are dissatisfied

by moving back to the assessor role. Certainly, assessors can be less tolerant of errors by assessees they have judged early in the interaction to be less competent.

As a teaching device the simulation appears to have considerable appeal. It offers an opportunity for practice of essential skills in a safe environment; safe, that is, for patients and assessees themselves. It guarantees assessees the chance to practise a particular skill by a specified deadline and that they will be seen doing it, which is not always the case on a placement. It also gives assessees a sense of achievement, having got the basics under their belt, so to speak. As a form of assessment, however, it is seriously flawed. It has neither inter- or intra-assessor reliability, its purposes are confused and it raises anxiety among assessees to an unacceptable degree. It is also expensive in terms of time (and therefore money) for assessor preparation and participation. OSCEs appear to make excellent teaching but poor assessment devices.

## 4.4 Scenarios

Another 'half-way house' on the road to direct observation in a clinical environment is the scenario. This is almost the simulation without the exam element. It differs from OSCEs in so far as it is not about basic skills but about the application of learning on a broader basis. This lecturer's comments make its function clear:

> *'I've just done a session on pressure damage risk assessment and this afternoon we're looking at case study, a scenario of a patient who has got a pressure sore and that'll give me some sort of opportunity to assess whether the theoretical concepts we talked about this morning can actually be applied – it's not in real practice, of course, it's in the rarefied atmosphere of the classroom but how they're making that application of information that was given this morning in the context of a scenario about a patient.'*
> (Lecturer)

This has an obvious value as a way of following up theoretical learning and seeing whether assessees can integrate theory and practice. It guarantees the presence of someone who understands the theory and can therefore make an informed decision about how the assessee is using it as they practise. It is a useful teaching tool and could perhaps be used in assessment, although it is likely to suffer from many of the disadvantages of the OSCE.

## 4.5 Summary

Intermittent observation by lecturers in clinical environments has proved unreliable, as has observation of simulated practice by lecturers. Scenarios are valuable for trying out information learned a short while before but are not widely used for assessment. All are valuable teaching devices to make explicit the links between theory and practice.

The research evidence suggests that only an assessor who is present in the clinical area for a sustained period can reliably assess practice (together with relevant theory and understanding of its application). It also indicates that lecturers perceive the building of trust through visits to clinical areas to support and advise assessors and mentors as slowly but steadily improving the validity of assessment. As one interviewee said:

> *'I think the only way that you can really look at it is actually to observe it happening ... it's much easier to do than to talk about it.'* (Lecturer)

## 5.1 Introduction

Listening to assessees, it soon became obvious that there is an intimate yet complex relationship between work, the work environment, curriculum (explicit and hidden) and assessment. Paralleling the description of a curriculum in Chapter 1, phenomenologically both work and assessment are oriented *towards* something *for* someone with a third dimension being the *act* of engaging in work and assessment. Where work is about the transformation of materials/objects in the environment or even the environment itself, assessment in the practice area concerns:

- how these manipulations and transformations are performed, that is, the quality of 'doing' and 'action'
- their effects and outcomes on people and the environment
- the transformations within the individual who performs these.

Critical to this process are the quality of the act of assessment itself, its procedures for gathering data and its frameworks of analysis.

In using assessment booklets what is being assessed? The apparent obviousness of the answer to this question has already been undermined in earlier discussions of observations and interviews. Most are aware that assessment may be done for many purposes other than to provide a realistic judgement of performance. Few doubt that assessments are subjective with assessment criteria open to interpretation. Assessees often refer to these issues; indeed they frequently complain of the difficulty of actually seeing their assessor and other relevant staff:

> *'I suspect that many people have little confidence in those booklets because time and again people say well nobody ever sees them anyway. I mean there is at the end of the booklet space for both the link tutor whoever the link tutor may be and if you ever saw them on the placement which frankly I rarely have done; and also a a space for your personal tutor. But again it's very much, of what relevance does the link tutor's comment or signature have in that booklet if they've never met you on the placement? And even if you take time to discuss it with your personal tutor, they haven't, I still hardly see the relevance of their comments if they've never sort of been with you in the placement.'* (Pre-registration student, Adult branch)

Whether these problems are a matter of a lack of resource or of inappropriate resource management varies from institution to institution. It remains the case that there are considerable problems faced by institutions, their staff and assessees, some of which must give concern regarding the implications for the quality of the assessee experience as a preparation for professional practice. This chapter focuses upon:

- the subjective effects on the assessee of their experiences of practice
- their perceptions of what they believe they have or have not learnt
- their perceptions of the quality of the workplace as a learning environment
- their perceptions of the appropriateness and effectiveness of assessment procedures and frameworks
- their perspectives on the resources and management needed to facilitate their learning.

## 5.2 Crossing or closing the divide: theory/practice

Both theory and practice are organised in terms of a sense of subjectivity, of 'agency', of being a subject. In philosophy reference may be made to the Cartesian I-think or the I-do of the pragmatists and experimentalists as the basis upon which knowledge, decision and action may be founded. Contemporary philosophy, particularly continental and post-modernist, has deconstructed the primacy of the I-think rendering subjectivity as well as objectivity highly problematic. It is important, therefore, to consider issues of theory and practice without falling into a naïve dichotomy. Subjectivity, here, refers to the organisation of thinking, doing, feeling and engaging with others around such language positions as 'I', 'you', 'they'. Theory as I-think and practice as I-do do not so much divide as traverse or permeate each other in a complex mesh of feeling and intersubjective discourse where private experience and knowing becomes tested or explored in public arenas. The emergent models of curriculum and assessment initiated in the preceding chapters must increasingly take into account the knowing subject that emerges within this double-faced arena of private/public subjectivity.

It may seem that in interviews with assessees and staff there continues to be the sense of a divide between theory and practice. However, these terms are more typically used as shorthand to refer to the two places of work for the assessee: the educational institution and the clinical practice area. Listening to assessees it becomes clear that there is a blurring between theory and practice when referring to the forms of action necessary to accomplish a task or a broader care plan. Action is underpinned by knowledge or theory; otherwise it is 'doing' without an awareness of consequences and reasons. This already implies not only two kinds but levels of both practice and theory: 'armchair' theory as distinct from theory grounded in practice. In the following extract, an assessee distinguishes between theory as sitting and listening as distinct from practice as doing. She explains why she is happier now that she has been on a long placement:

> *'It feels better because I wanted to be a nurse and now I feel as though I'm doing nursing and it's much easier to learn about nursing while you're actually doing it as opposed to sitting in the classroom and talking about hypothetical situations. And I think a lot of nursing, although of course it's important to have the theoretical background is about doing um and applying principles and concepts. And I guess it's also much more satisfying when you're actually doing as opposed to being passive, well it is for me anyway, um sitting and listening.'* (Pre-registration student, Adult branch)

Already she understands the necessity of underpinning action with principles – she has moved beyond the level of mere imitation, or doing without understanding. Although it might be claimed that assessees have a purely pragmatic motive, it is clear that this is not without a theoretical side. During interviews this pragmatic motive is expressed as two concerns:

- to increase the range of experiences of some desired core of practical skills
- to learn about situations, environments and conditions in ways which bring in a more theoretical knowledge base.

The pragmatic motive in each case may well initially be reduced to being able to fit in and be seen to function in ways that are thought to be demanded by experienced nurses. However, the pragmatic and more narrowly-defined motive of wanting to be useful are not the only possible motives. In focusing upon the more complex and layered relationship between action and theory other motives are possible.

> *'What may be less of concern is what might be called a critical motive, the motive that leads to a different kind of action, an action that may change structures/circumstances to meet alternative criteria/concerns.*
>
> *This may also be linked to something that could be called 'principled motives' – e.g., social justice, human rights.*

*Each of these motives imply a difference in kind concerning the nature of the action implied.'* (Researcher's theoretical memo: 11)

Although these motives are perhaps suspended by the imperative of the pragmatic motive requiring the assessee to fit in, or to pass as a member of the profession, assessment procedures need to attend to them. Assessment should be framed according to the broader question: to what extent has an assessee adequately theorised the practice experience itself in order to be able to explore its possibilities fully? This question is discussed further in Chapter 8.

## 5.3 The assessee role

As the central focus of assessment and learning, the assessee role needs to be theorised. Being an assessee means that the practice experience is a curricular process and all engagements in the work process are subject to assessment by 'expert' judges. This means there is a lot at stake for assessees, who often appear desperate to be recognised for what they are and what they aspire to become – a very Hegelian motive. Rather than master and slave, it is a struggle between professional/assessor and assessee. Each desire to be recognised by the other as having status, needs, interests, knowledge and skills. For younger pre-registration assessees this may occur as a process of transition towards adult working practices and cultures where status is gained. For mature assessees the experience is of a loss of recognition once enjoyed. Through this contest there is an attempt to construct the self as a knowing subject, the nature of that knowing, and the status of the knowledge possessed, created or enacted. Many of these issues were illustrated in the following exchange:

**Student 3:** *'What I found very difficult is um I came from a nursing background, being quite an a competent nurse um. I knew nothing. And my first day I couldn't do a blood pressure er I'd been doing them for years. And I wanted someone to check it. I' It's very very different.'*

**Interviewer:** *'But… Explain explain that a little more that that you couldn't do a blood pressure although you'd been doing …'*

**S3:** *'I felt didn't have the competence.'*

**I:** *'Really?'*

**S3:** *' Yeah, I just felt I was back to square one and I knew nothing.'*

**I:** *'Is it because they were doing things differently or was it just simply your change of status?'*

**S3:** *'Just change of status'*

**I:** *'You're now a student and …'*

**S3:** *'Yeah.'*

**I:** *'I can't …'*

**S3:** *'I'd gone from being able to look after a ward to being a student again – I did find that difficult and as far as being a trained nurse in certain placements you do find it very difficult um. When I was on post-natal ward, I could give, as a trained nurse I could give intravenous um medication, I could do fib, um but as a student that was taken away. I wasn't allowed to do anything like that um. But other than that I mean it's been brilliant. I found it very … not scary as such but … I just felt as though I was, that I was useless [laughs]'.*

**S2:** *'I think that's um … the first, I'm finding it difficult 'cos I've been a lecturer [in art and design] for 12 years and I went back. So I'm used to teaching and lecturing and things like that and suddenly to become the*

*student I found, I was quite angry my first day because I arrived at the [clinic/community meeting?] and because I had the student [model/ module?] they ignored me for half an hour and uh it's just the sta', it's the status thing. It's the dy, it's the dynamics. I find it really interesting, you have to laugh about it really. But it's like people see you as a student, and it's like "Oh that's where you're at". Obviously it's people's self-esteem and whatever. I think as a mature student I think it's sometimes more difficult because you're not going to slot into it right. It's like you with your knowledge, you're probably just a s knowledgeable as others...'*

**S3:** *'But then I think it could be ... the way I saw myself that I made myself go into that ... that position.'*

**S2:** *'Yeah you have to bring yourself out of it don't you.'* (Three midwifery students)

It can be argued that student (as opposed to assessee) status of necessity leads to restrictions on what can and cannot be done. However, more is at issue here than matters of safety and correct procedure. There is the subjective effect on the individual in moving from being one who knows something to one who is expected to know nothing; there is also a suspension of prior knowledge and skills; and, hence the construction of a sense of uselessness. Students must endure being doubted and often ignored which in turn hits at confidence; they must then find strategies to overcome the dynamics of the workplace, whether the private strategy of laughing at it, or some more assertive strategy.

A key question for curriculum designers and assessors must be whether the assessee role itself gets in the way of learning, and of creating appropriate learning environments. Is it, in fact fitted for the purpose of developing professionals. Descriptions of experiences of the first day on a ward are very telling in these respects.

## 5.4 First days

Feelings become very important in assessees' descriptions of their experiences; they either ground people securely in a situation where they feel able to learn, make decisions and act, or alert them to issues, dangers, or challenges which must be overcome. When asked about their first day on practice placement most assessees provide as their first word descriptor: scary, frightening, terrified, anxious.

**Student 2:** *'First day ... um well I it's become sort of a familiar feeling as, for me it's a great day of anxiety and dread. It's feeling totally like a spare part and feeling as though I should be apologising for my existence. The way I cope with that is knowing that I'm going to get over that where I will settle down and get to know what goes on in that particular placement, the specialty, the staff, the nature of the patients. But the first day you're so bombarded with everything being new it's difficult to know how to proceed. Um and then gradually that becomes easier. But it's certainly not a comfortable feeling. And I think a lot about being a student nurse is about learning how to manage your feelings of discomfort. And yet in spite of that learning how to function within the environment.'*

**Student 3:** *'Mmm I would agree with that. First days are always a bad thing because you, having to um meet a new staff, new routines um and i' it does feel like, you know, oh another student to take on today. You do feel like a burden. I quite, quite relate to that yeah. It gets a lot easier once the first week is over.'*

**S2:** *'I think although it takes a week to start settle down. To feel that you're sort of a working member of the team takes considerably longer and*

*generally it's only after seven weeks when I start to really feel that I'm getting the sort of maximum benefit, and then of course it's time to move on and go back to square one.'* (Pre-registration students, Adult branch)

Anyone starting a new job must be familiar with aspects of this description. There is a transition phase between being new, and of being a functioning member of a team. What is different is the effect of being a student in this situation – *'oh another student to take on today'.*

The same theme is addressed by a post registration assessee following a specialised programme:

**Student:** *'Even after being on the wards for eight-and-a-half years as a staff nurse and an EN 'cos I was an EN before that I knew my staff and I knew how to run a ward and manage it. Going out of nursing for 18 months and coming back into the ITU environment I felt I knew nothing at all. It was um, noisy, um extremely busy, very active um unfriendly I think at first because it's such a close-knit environment, everybody knows what they're doing, when they're meant to be doing it and you don't want to interrupt anybody and stop them from doing anything because they all seem to be busy as bees sort of with their patients. And you don't want to interrupt that because you feel that you might do something wrong and alarms are going off and you're thinking ooh ooh and it was it was totally nerve-wracking.'*

**Interviewer:** *'And how long did it take before you felt less nerve-wracked?'*

**S:** *'I'd say now and that's 18 months later [all laugh]. I'm being honest 'cos I've done the course now so I now understand why I'm doing things. I mean I was safe, in my practice um, if I didn't know what I was doing I wouldn't do it. And any results I'd get I'd check, get checked by senior members of staff. But, I mean I still do that now, but I know why I've done it and what I'm looking for and I've, I've analysed it before I go up to them and say this is what I want to do now ...'* (Post-registration student)

The management of feelings, learning how to function within the routines of the clinical area, waiting for the feeling of settling down must all take place at the same time as identifying opportunities for learning which will be the subject of assessment. This implies that entrance into a work area progresses by stages: for example, first impressions; becoming familiar with the goings on; and finally, membership of a fully functioning team. Again the assessee clearly identified the importance of understanding and distinguished it from a level of practice that was merely safe. Managing these transitions, however, may be hindered by the busyness or lack of preparation of people in the workplace:

*'Until they get to know you and then I think, they're very much, they give you the responsibilities [as] they've found out what you've done. But the majority because they can't tell what your background was, what you can do, it's very much quicker to say um "you can go and do such and such um do you need a hand?" rather than finding out what you can do to start with and then building on that. Um I found that very much at um [name] baby unit that I was on over Christmas. Um, there was one sister that I worked with, found out what I knew, about ventilation and the general baby care um and I got on really well and progressed quite quickly. Then in my last week, I was working with a nurse that had recently qualified that assumed I knew nothing. Um I was being asked about um babies' respirations and did I know what they were and that's when the baby breathes in and out [general laughter] and that*

*temperatures um were measured in degrees cel' Celsius. When she turned round and said what do you know about ventilations, so I told her, did she want to know about … and such and such and she just, totally gobsmacked. But that was her fault she should have found out.'*
(Mature student midwife)

The key issue here is the assessee who knows something as distinct from nothing. It is essential that the assessee, in order to fulfil the professional role, becomes a *knowing subject.* In order to facilitate this the assessor needs to get to know the assessee. This focuses attention on the role and practice of the assessor.

## 5.5 Being supported

The quality of the assessee's learning experience depends upon the kind of support received at every level – emotional, thinking, doing, sharing in dialogue in order to render the private open or public:

*'I've just been out since September on community at the moment um which has been brilliant. But that's due to my [mentor] … But I know from other students that the preceptor-student relationship is really important at the beginning because either sink or swim. I think a lot of students it's depended on their character rather than the actual teaching they get as to how they cope with it. Mine has been really positive and I've worked within a team and as the other um student said, you know, I felt very well supported.'* (Three midwifery students)

Just as assessees may need to be assertive, there is also a need for assessors to initiate. When this does not happen then being assertive begins to feel more like having to hassle. Both assessees and staff recognised that this requires a certain kind of character well beyond that needed to be a good professional.

*'I feel really strongly about this that the whole system of [mentorship], I think fails enormously because it seems to me it's a role thrust upon people whether they like it or not. They have very little preparation. Because of the sort of general lack of resources generally in clinical settings there's more than enough work cut out for most nurses in dealing with the patients let alone also having to assess a student's needs and therefore I think both people are compromised both the student and the [mentor] and also the patient. And I feel that student learning should be prioritised not necessarily by the preceptor but it needs to be prioritised by someone in the clinical setting and it very much isn't the case so you can feel as though often your sort of, well I do um an added burden which I think as the training goes on now I'm a 3rd year I'm more able to work independently … which starts to feel a little bit easier but still just in terms of completing assessment booklets although I'm able to complete my part of it by myself it's still a continual hassle to get [mentors] to fill in their bit because there is no time specifically allocated to that. And as there's never enough time on the shift anyway for all the sort of various um jobs and also increased documentations to have the additional burden of um filling in an student assessment booklet it's, that what it feels like, a burden.'*
(Pre-registration student, Adult branch)

The feeling that they pose an additional burden in a busy clinical area was expressed by many students interviewed. While this is not in itself new knowledge (Stones, 1986; Peteet et al., 1989) it represents an indictment of the current system that, as pressures in the workplace appear to be increasing, measures to support those who are assessed and assessing have not seen a commensurate increase in recognition and resourcing.

The sentiments expressed by the student above are echoed by another in the same group who says he had to create his own learning opportunities:

> *'I mean I don't think a lot of the placements were prepared for student nurses … the nursing home I was in for seven weeks for my elderly care placement. I mean it was a really really nice nursing home but um there was only one qualified member of staff on at the time and their time was really taken up on working as a nurse in in that situation and their input with me was was quite limited really so … I spent a lot of my time really thinking of ways of how I could get something out of this placement 'cos I was because the feedback and and what this person could give me was quite limited.'* (Pre-registration student, Adult branch)

Such experiences are not unusual. However, where institutions have a reasonable level of resource and appropriate, tailor-made professional development programmes for tutors, assessees report a higher level of satisfaction with their support. In particular, they seem to appreciate some combination of the teacher/practitioner role, as in these comments on the nurse practitioner employed in some trusts:

> *'I thought that was a very valuable role because it's somebody who um who's got experience of teaching, who's got experience of students because they're used to mentoring them and seeing them on the wards and they're also part of the nursing team, so they know the nurse's perspective and it's somebody that the students can respect because they're not just a tutor with no hands-on care, they're a teacher … who is also a nurse and works as a group, as part of a team … and the difference between the information and the lectures that s' somebody like that can give, all the support they can give you on the placement, there's no comparison, they're very valuable people … for a student, they're a good link also between theory and practice 'cos while they're doing something practical they're also pointing out the theory behind it to you. So they link up things in a smooth way and they understand everybody's perspective.'*
> (Pre-registration degree student, Mental health)

The task is to find the means to prioritise learning and reduce the bureaucratisation of assessment.

## 5.6 Learning something and doing something

Assessees contrast the activeness of the clinical area with the passivity of the classroom. Simplistically it would seem to be the difference between active learning and passive learning as well as between doing and reflecting. Again, as one might expect, the situation is more complex.

Being in a team or acting alone with a caseload requires more than a knowledge base. There is a public demand that the professional is one who knows, is a *knowing subject*. It is a matter of the exercise of knowledge through action that is in some way made public and found to be valid and trustworthy. Being accepted as a knowing subject means one is assumed to have the capacity to process information into knowledge which in turn informs decision-making as a basis for skilled action. Patients look upon the professional as one who is supposed to know; the incapacity to perform is a kind of betrayal of their trust in the professional. Being *only a student* is one way of escaping such blame. However, to become accepted as one who is *supposed* to know means reducing one's withdrawal into student only status. The task then is to break through the boundaries of student status without losing student status. It is a particular kind of catch-22 which can only be resolved if the clinical area is organised as a learning environment. In this wider sense, the learning environment refers to the structure and the processes through which knowledge is created, produced or reproduced, disseminated and applied for professional practice.

Interviews revealed that learning is supported when there is sufficient opportunity to talk. Community placements seem to offer more occasions when this happens:

> **Student 1:** *'Community's much more it's all one to one you're and you're in the car with your [mentor] and you can discuss every case after you've been in, into the house, you can go out and talk about it and there's lots of time whereas …'*
>
> **Student 2:** *'When the client's are there is what is, it's very …'*
>
> **S1:** *'Yeah, you've only got one person's demands on you at each time whereas in the ward setting you've got, you've got maybe several people that all want some time from you and the [mentor's] trying to support them and trying to support you and, and they're torn. On the ward it's more difficult for the [mentor] than the assessee whereas in community, said it's one to one.'* (Three midwifery students)

In the clinical area, *learning something* typically involves *doing something.*

> **Student:** *'Where I am the type of clients I see, the life of the client is the most important aspect uh. The area I work in is very uh deprived, one of, it's the highest area of social deprivation in in the borough itself, so it's the most important figure key point of uh what, you know how it affects the person's everyday living uh things such as drug and alcohol abuse are very rife, especially with the clients that I deal with um because it's their way of escaping the monotony and the deprivation itself.*
>
> *… you find that you you do get frustrated because you're trying hard so hard to do something to help somebody, somebody to do something for themselves and there's all these pressures and issues cropping up that are actually stopping that person from moving on and that you find yourself becoming cynical in a sense that you know, what good am I doing here, what and then you have to then again reflect on … you must be doing something for this client, you've to sit back and think about well what, you know, if you weren't seeing this client what would happen then?'*
> (Post-registration student)

As he went on to describe, this assessee always looked for criteria of success. This involved looking at the positive in dealing with clients. He gave the example of a client who was locking herself away, refusing contact. He and his assessor went into her home with a view to sectioning her. However, they decided to try and contain her in the community. Thus, he tried to see if her social situation could be improved. He succeeded in keeping her out of hospital. She recovered, he said, and started going out again. She was encouraged to claim benefits and succeeded. Following that she had more money to improve her quality of life, cooked herself proper meals and integrated better. Thus, 'you've done something to help'.

It is this quality of helping, of making a perceivable difference that reinforces the value of work in the clinical area. It also creates opportunities through which various forms of practice-based learning may take place. These may be difficult to plan for and to fit into assessment schedules. Nevertheless, there are opportunities that do take on a structure if conceived in relation not simply to learning contracts but the development of projects negotiated with clinical staff or assessors. This kind of possibility began to be elaborated during an interview with a post-registration assessee who was talking about the difference between the learning contracts for her present programme compared with her degree.

> *'[The current ones] are completely self directed … you aren't told what to do, you have to develop your own ideas based on your own learning needs and it's up to you to go and see the mentor, you don't expect the mentor to*

*come to you and say well I'll supervise you … you have to have a plan in mind. Perhaps just general ideas to start with and then you would discuss that with your mentor and see what was, what was practical and what what they recommended if you were on the right lines. So they would channel you but y'you'd need to have that initial idea yourself.'*

(Post-registration student, Cardiac programme)

In more detail, in order to develop a learning contract:

*'We set an objective, ways that we are going to meet our objectives um and then we produce our own evidence in conjunction with um logging of assessments by the tutor. So for example, one of our objectives might be to assist in the insertion of a temporary […] wire. Now I could say that I done that, not having done it um but you would have evidence from, you you'd have um proof of of signatures and what have you from the mentors to prove that you'd done it.'* (Post-registration student, Cardiac programme)

The image presented in this extract is of someone whose acts of 'knowing' are still under guidance.

## 5.7 Knowing something

The transition from being a subject who looks to others for validation to someone who makes their own case for their own status as one who knows is clearly important in professional terms. In reflecting upon where the source of knowledge is the same assessee states:

*'I think when you first start out it's something you get from books but as you progress to pass qualified, yeah you still get it from books but that becomes, it's still a significant part of it but it's it's also what you bounce off other people and what you um based on your knowledge from books it's then what you can deduce in your own way of thinking. So I think yeah books are very important and literature and articles. And I think they're a good foundation. And I don't think they become any less as you progress but I think other things add up, you know you get ideas from other people.'*

(Post-registration student, Cardiac programme)

Professional knowledge moves its centre of gravity away from books to include the ideas of other people. The next transition is between receiving ideas or knowledge from some outside source to creating it:

*'… I mean certainly in my essays where I'm looking to. Uh and one of the things that my degree taught me was to look at ways of changing things and being innovative. So I think I do tend to write my essays from the, well this this and this has happened so what about this? If that works, couldn't this work? So I think, yeah you have to be crea, creative and innovative, if you're going to progress.'* (Post-registration student, Cardiac programme)

It is no longer a straightforward matter of applying knowledge from elsewhere. Progress includes one's own creative contribution. New knowledge, however, may imply the need for changes in practice; this requires the skills of persuasion or waiting until the time is ripe. Thus, if you had such an idea:

*'You'd probably hold on to it until it's appropriate to make it known. I mean for example, I came up with an idea … and put that to my manager and we're just going to hang onto it at the moment and when the opportunity arises we're going to discuss that and take it further. So, I think you just have to be adaptable you can't (bolsh) in and say I want this and I want to change that. I want to do that, because you can't. As one person it's very very hard. … It's about fitting it in when it's*

*appropriate but making people aware that you have got ideas so that they will come to you possibly.'* (Post-registration student, Cardiac programme)

There are clearly, limits to freedom of decision-making. However, this particular post-registration assessee feels fairly free to make decisions:

*'I think that I'm fairly free but within certain constraints obviously um … medical decisions impinge on us as do occupational health decisions so you're free within your remit but there's certain parameters um and I suppose on the grander scale things like economic factors and what have you I mean yeah based on what I've learnt I would like to see all of my patients have a great cardiac rehabilitation programme that would be great and I can do something towards that. But I can't do what I, you know my whole decision-making process to be involved in, you know I'd like to see a, b and c and because of the constraints I could probably only do a.'*
(Post-registration student, Cardiac programme)

The major constraints as she saw it included the patient's clinical condition and the demands of other professionals.

## 5.8 Having a special identity

Assessees tended to associate themselves with a particular branch specialism or setting or with being a nurse or midwife. This seemed to affect their attitudes and dispositions towards knowledge, being critical and engaging in action.

**Student:** *' Right, and mental health is quite separated in many ways isn't it? I think.'*

**Assessor:** *'Mm it's a very different kettle of fish well in a way it's a very different kettle of fish but on the other hand it doesn't have to be but it is kept very separate I think from adult nursing. Erm and again thinking about the CFP and Project 2000 they hate that common foundation programme the students hate being all together.'*

S: *'Do they?'*

A: *'And I think that's something about a lack of identity you know I want to be a mental health nurse, why am I in these lectures with adult nurses you know they are not the same breed as me I think there is a lot of role confusion and then when they get into branch programmes then the real divides come to the full but the students seem to feel that that's when the course really begins for them is 18 months in but I think that is something about nurses wanting a strong identity I think and fear of all being pooled together the fear is that that is being diluted somehow. That specialism.'* (Student in conversation with assessor)

There are a number of implications for the development of curricula and assessment strategies. However, more observational data needed to be collected in Phase 2 of the research before these initial insights could be elaborated.

## 5.9 Assessing

When assessees discussed their experiences of being assessed there seemed to be few shades of opinion. At one extreme was the typical statement:

*'The way in which we're assessed on the wards with assessment booklets as far as I'm concerned establish absolutely nothing. They're about demonstrating you understand principles, but whether or not I understand principles of sociology and psychology and physiology are very*

*helpful but they make no difference to me as to how I feel on the ward when I'm dealing with a patient. And they make no difference as to really to my understanding of what's going on and whether I'm going to do the right or the wrong thing. They purely establish whether you can yes perhaps relate the principles that you've learnt in college to on the ward. But in terms of reinforcing what you think you know but you need to know I don't think they're at all helpful.'* (Pre-registration student, Adult branch)

At the other extreme, typical of assessee experiences in the community:

*'With this particular course I am quite confident because a lot of the assessment, you know 50% of the demand for the course is actually the assessment, the assessment is actually done by the person in the practice area … they know the what the job entails, the problems that can happen, probably experienced, probably gone through similar you know similar experience themselves and maybe had to do what I did and gone to … So I'm quite confident that if the that part of the assessment actually does work because it's not just, you know, it's not just the tutor coming out to the from the college and saying "right let's do this assessment" and get on with it. The actual, your practice tutor, is actually, you know, you see them on a regular basis, you know, they're aware of the issues and the circumstances that you're working under.'* (Mental health student, Community)

Such interviews provide a basis for discussion. However, only through shadowing assessees and assessors can further detailed insights be gained.

## 5.10 Implications for resourcing assessee learning and assessment

Before the assessee even reaches the practice arena, a number of physical resources can have a profound effect upon the eventual perception and experience of practice. Large cohorts, inadequate classroom space and the geographical mobility often required between areas used for formal teaching, residential accommodation and practice areas used for placements, can be stressful and disorientating for the new assessee. A child branch student said of her first six months:

*'I felt like I was in a state of perpetual motion. No sooner had I found where I was supposed to be and settled than it was time to move on. I lay awake at night worrying about whether I would get to the right place at the right time next day, and sometimes when I did, I'd be too tired to take anything in … exhausted with the effort of just getting there.'* (Pre-registration student, Child branch)

Assessees' frustration increased when staff shortages meant that lectures were cancelled at short notice: many complained of wasted hours travelling and the subsequent inability to settle to any useful study. For many assessees, a dearth of adequate common room facilities meant little opportunity for relaxation between studies and limited scope for the development of peer support and the mutual exchange of ideas.

Many had experienced difficulty in accessing their personal tutors and staff responsible for organising their practice placements, as these offices could be up to 50 miles away from where teaching occurred, and their opening hours coincided with assessees' lectures or travelling time. Telephone contact was reportedly unreliable and little use was made of electronic mail and associated technology. This student describes her abortive attempts to discover whether her practice allocation had been re-arranged following a ward closure:

*'By the time I got to the [education] department, it was like the Marie Celeste – not a lecturer in sight, all the offices closed. I just had to push a note under her [allocation secretary's] door.'* (Student)

For those who travelled independently, cost was not the only consideration. Limited parking at educational institutions and particularly at hospital-based placements where the assessee arrives at times of peak occupancy, compounds the difficulty. A mental health branch student described his 'frosty reception' when he arrived late at the start of his hospital allocation after spending 20 minutes looking for somewhere to park:

*'It got me off on a bad footing – like they thought "here we go, another irresponsible student".'* (Pre-registration student, Mental health programme)

Other assessees reported being *'too stressed by everything to do with the course so far to make anything of the practice situation when it eventually occurs'*, while others saw the clinical component as *'light at the end of the tunnel'* and that *'at last we are seeing what nursing really is about'*.

In organisational terms, large cohorts of assessees must be accommodated and distributed across the various practice areas in accordance with the requirements of their programmes, while maintaining adequate levels of support, teaching, supervision and assessment. Areas which are mandatory for assessees' experience often encounter a constant throughput which allows assessors little time for personal reflection and 'recharging' between assessees. Although numbers on post-registration programmes frequently are smaller, the specialist experience may be concentrated in one or two small areas of practice (ITU or CCU for example), entailing constant supervision by assessors.

Discussion with lecturers, assessors and assessees has shown that able, supportive clinicians are the most valuable learning resource in any clinical placement. Too many appear to be overstretched, exhausted by the competing demands of their role and lacking support in the workplace.

*'I like having students. I really do, but there should be some way of getting dedicated time for all that, all that entails. As it is, you're busy and the students just fall through the net really. You can't supervise them all that much – it's even a struggle just getting their assessments done sometimes.'*
(Staff nurse assessor, Surgical unit)

This area of focus (the sheer pressure of work and its effect upon assessees, teachers and the whole assessment process) is developed further in the subsequent discussions of workload and the culture in which nursing occurs. What emerges from explorations of assessors as a learning resource, is a picture of inconsistency in terms of the support they may receive to undertake this crucial role. Regular assessors' meetings to address such concerns and receive updating, may be a requirement of the role, but these are ignored when competing pressures of patient care arise. Records of attendance at assessors' updating meetings provide reliable evidence of the extent to which this happens, identifying specific periods when attendance fell well below average, and clinical areas where a significant number of assessors with previously unblemished attendance records consistently failed to achieve their annual update. Assessors who report that they are well-supported tend to be from clinical areas which have a close and supportive relationship with the link teacher or lecturer/practitioner.

## 5.11 Tangible learning resources in the practice environment

Tangible learning resources in the form of access to programmes, educational and reference material, academic support and time for people to avail themselves of these are not present in all practice environments. The difficulties experienced in making time to attend assessors' meetings also apply in relation to study days, conferences and post-registration

programmes. Nurses wishing to avail themselves of these, even to fulfil their PREP requirements, are increasingly prepared to undertake at least a portion of this in off-duty time.

> *'I hadn't been to anything relevant, you know, educational, for about two years, so I said I would like to go to this series of seminars on child health. Well, it's only part of my work I suppose, so I was quite resigned to having to do pretty much all of it in my own time.'* (Staff nurse assessor, Renal unit)

## 5.12 Distance, scarcity and cost of relevant programmes

Some areas of nursing have become particularly specialised and only attract small numbers of practitioners. Specialist programmes or conferences may occur infrequently and at considerable distance from the nurse's place of work, incurring additional personal cost (inconvenience, disruption of family schedules, incursion into leisure time) and a manpower implication for the practice area which requires alternative staffing over prolonged period(s) of absence. Associated travelling and subsistence costs are increased. A clinical nurse manager in the north of England talking about a nurse assessor for post-registration community and surgical modules from her department, says:

> *'Looking around the country, there are not many places to do a lot of these courses either … for nurse endoscopists or nutritional courses. They're few and far spaced out. Our Stoma care nurse is doing one now, in [town, 300 miles away].'* (Clinical nurse manager)

And about the same nurse:

> *'She goes twice a month for two days. Usually it is a Friday, so she goes on Thursday and the Saturday she comes back. I know sometimes her husband is able to take her, but it's a hell of a way from here.'* (Clinical nurse manager)

In some instances, the availability of continued funding for a particular programme depends upon the clinical area taking up the allocated places on each occasion. This requirement may have been stipulated by the educational institution or the sponsoring trust or employer, and can impose real difficulties in managing the clinical environment with depleted staff. There is further evidence that where such rigid impositions occur, clinical staff are not necessarily acquiring the skills and educational opportunities most relevant either to the area of practice or to their personal professional development. While there is a strong indication that this is a remnant of an earlier tradition in the allocation of financial resources for education, there is still a feeling in some areas that *'if you don't use it, you'll lose it'*. The manager of a nursing directorate describes a new post in the trust:

> *'It's an attempt to get it all under one umbrella. All the training and education that goes on somewhat haphazardly. Nurse training doesn't really fit in – although her [the post-holder's] remit is supposed to be managing post-registration education and training with the university. She has to sort out what we need in terms of courses and ensure that the courses are suitable for the particular clinical area.*
>
> *In the past, wards have seconded people onto ENB programmes without really knowing why they are sending anyone … you might be working in an area which never sees a leg ulcer but you're allowed two people on the course every year and you use the places for fear of losing them. There's still an element of this about but you can't afford the people off the ward for the duration of the course. So you're punished in two ways. You lose staff and they come back with all this knowledge which is never going to be useful or relevant in the area where they work.'* (Manager, Nursing directorate)

Funding for educational programmes to prepare sufficient qualified assessors in all specialties appears to be an almost universal problem; it may be strictly rationed by trusts increasingly experiencing difficulty in meeting their budget commitments. Attempts to circumvent the problem have led some trusts to impose in-house programmes, the standard of which is immensely variable. Some are delivered conjointly with an educational institution, attract a credit-rating and offer assessees a convenient, relevant educational experience.

> *'We have to ensure that all the staff get regular teaching and updating on basic life support. We [lecturers] work with the trust resuscitation officer to provide this … and we all work together to assess them. Then the permanent staff in the [A&E] department get advanced life support teaching and we do that in the same way … working together.'*
> (Lecturer/practitioner, A&E)

The demand for programmes is enormous. Not only are all assessors required to be appropriately prepared, usually involving secondment to ENB 997/998 programmes or their equivalent, but if they work in any specialist area they will be expected to acquire relevant educational preparation for this. Again, pharmaceutical and appliance companies may provide a useful source of funding for practitioners to attend conferences and study days, with some providing sponsorship, a bursary or scholarship for an individual to attend a recognised programme.

> *'[Manufacturer of surgical appliances] agreed to sponsor one nurse from here on the stoma care programme. We use them for any extra training they can offer. We've found them excellent. And I presume there's lots of other companies as well who would do it.'* (Clinical nurse manager, Colorectal surgery)

> *'You can always rely on [company] to give us something towards any conferences there are. The firms are quite generous to us [laughs] but nothing like as much as they'll give the doctors.'* (Senior midwife)

Other programmes are not as educationally sound, may not offer accreditation and may be delivered by individuals without a teaching qualification. Some which are delivered free of charge by various drug companies may present an incomplete portrayal of a clinical problem and its treatment, to promote the company's products, although many presentations by pharmaceutical and appliance companies may offer sound and balanced information and an invaluable opportunity for practitioners to handle new equipment and familiarise themselves with its application.

> *'That was a rep on the phone. She is coming here next month showing us the new infusion equipment. They've got these false chests and things where you can fiddle with lines. She'll set it up in the side ward and I'll get all the ward nurses down as well as those on the unit.'* (Senior sister, Haematology unit)

## 5.13 System overload and 'ethical' considerations

Throughout the research, practitioners have described themselves as repeatedly failed by a system which requires them to be educated and updated but lacks the resources to support them. They are quoted as

> *'prepared to harness any available resources'* to get the education they need. They will *'beg consultants'* as they *'try to get to meetings and – but there is never any funding for nurses'*. And sometimes they are *'lucky and a consultant is able to get places for us on things that come up which he thinks we will be interested in'*. They *'have no hesitation in scrounging from this firm or that'* and *'buttering up the reps shamelessly to get money from drug companies'*. (Haematology sister, Clinical nurse manager, Specialist nurse, Senior midwife, Paediatric ward sister)

The only stipulation, repeated in a variety of forms, is that the potential source of this funding is thought to be '*completely* ethical'. A request to define this provoked the following responses:

> *'You know if they are very ethical, not unethical at all. If we don't find their products suitable or a patient doesn't like them at all, we can use any other firm's appliance.'* (Nurse manager)

> *'If they don't push their own product like nothing else would do the job and when they are willing to talk generally about a condition, not just promote their own treatment of it.'* (Practice nurse)

Several midwives defined ethical practice in this context with the same example, quoted in the following graphic description:

> *'Firms which do not flood the third world with formula milk.'* (Midwife)

## 5.14 Library resources and access to IT

While assessees on recognised programmes of education (pre- and post-registration) are generally able to access library facilities from the 'parent' educational institution, this access is often limited both by intent and by forces over which individual assessees have little control. Assessees on clinical placement may be geographically distant from reference facilities on campus, while departments of nursing and midwifery education, whose large assessee numbers are late-comers to university-based programmes, are frequently sited in obsolete hospital premises, a distance from the central campus. Written assignments to be completed during clinical practice may require all assessees to have access to the same material over a limited period, and while separate library and IT provision may exist on some sites, the range of hard copy material is liable to be limited, as is the availability of specialist personnel to help and advise. Assessees may work unsocial hours or at the times the facility is open, leaving only limited break times for the selection of appropriate materials.

A further problem then arises where there is sparse provision for the safe storage of library books or videos in clinical areas. Assessees complain of instances where borrowed material has been misappropriated before they have had the opportunity to get it home. They have been held responsible and have had to pay for its replacement.

Computer access to the parent educational institution by assessees on placement is fraught with difficulty. Many assessees do not have personal computers and rely upon site provision of any facilities they may require. But IT provision in many clinical areas is restricted in use to patient record-keeping and administration; where additional facilities *do* exist, systems are frequently said to be incompatible.

Although many trust hospitals visited have library facilities and offer access to literature searches through CD-Rom, subscription to CINAHL etc., use by assessees may be limited to certain hours, require pre-booked appointment or be dependent upon library personnel being present. Books may be available on a reference basis only, and demands for access to facilities and services may be conditional upon these not being required simultaneously by medical personnel.

> *'We have a lot of difficulty with the library here. They limit the service to the doctors really.'* (Pre-registration student, Child branch)

> *'Library resources at this hospital are woefully inadequate.'*
> (Pre-registration student, Mental health branch)

Where they challenge this situation, assessees are told that the trust's first responsibility is to its own staff or that the medical faculty contributes the greatest proportion of finance for the library and must have precedence.

Facilities in community placement areas appear to be even more randomly allocated and less accessible. Many more remote or highly-specialised clinical areas have attempted to provide their own store of reference material. The danger here is that books and articles may be retained long after they would have been withdrawn from use by the library service and superseded with more topical material.

All the difficulties encountered by assessees are endorsed by assessors. A primary care lecturer expressed sympathy for assessors working in distant rural locations:

> *'I feel sorry for these people in the community. There's no way they're going to be allowed to use the hospital library now it's a [different] trust … and they certainly aren't going to trek across to the other side of the county to use the university library. Even if they'd time, I don't think they'd be allowed to borrow from there – as general public they could use it as reference.'* (Primary care lecturer)

Although they assess pre- and post-registration assessees, many assessors are denied access to the educational institution's facilities unless they are undertaking a current module of study with that institution. An assessor in a surgical directorate tells her adult branch assessee:

> *'You have to be willing to put in a lot of time looking things up but at least you're lucky … you're doing your course here so you can use the library, which is more than we can.'* (Assessor, Surgical directorate)

In relation to the trust hospital libraries, many familiar complaints emerge. Even though they are employees of the trust, assessors report that their needs are not catered for; with all available resources apparently allocated for medical education. Despite the promotion of an evidence-based system of health care advocating availability of resources and the education to use them, open access to information, a commitment to lifelong learning and the integration of allied professional opinion, this remains something of an Utopian dream for many practitioners. Progress towards professional integration is variable in the extreme, and in some places, where medical appropriation and domination of resources continues to prevail, it is painfully slow to emerge. Many practitioners described the strategies they employed to acquire the material needed to support their educational role.

> *'We buy journals ourselves and literally scrounge them from anywhere we can.'* (Sister assessor, Medical unit)

> *'We are very lucky that we've got a healthy trust fund in the [haematology] department, which pays for stuff to be got from the British Library even though [A and B] are nurses. Nurses aren't funded to get information. So we practise a bit of deceit here and put the requests in the doctors' names. They don't mind. They let us do that.'* (Clinical nurse specialist assessor)

Other practitioners collude with this deceit; clearly feeling it to be justified in support of the assessment function.

> *'Our link teacher gets anything I need in her name. She's able to do that.'* (Assessor, Care of the elderly ward)

> *'So I sign things out for them in my name. I photocopy journal articles too. After all, they're helping our students out there.'* (Community tutor)

It is disconcerting that access to a learning resource involves an element of dishonesty, compromising the code of professional conduct which emphasises truthfulness to *'justify public trust and confidence and uphold and enhance the good standing and reputation of the professions'* (UKCC, 1992). Indeed there is a conflict of ideals for those who would attempt to exonerate this deception by reference to Clause 14 in the same code: where they are exhorted to *'assist professional colleagues, in the context of [their] own knowledge, experience and sphere of responsibility, to develop their professional competence'* (UKCC, 1992). It becomes the responsibility of a

discerning assessor to evaluate the usefulness of the material acquired through these strategies. While many are able to do this, some may not be as equipped to make the necessary distinction.

> *'Sometimes the reps will give you print-offs of articles. Mind you, they tend to promote their own product like this, so you have to, well, take it with a pinch of salt, somehow, all the claims they make. If you had all the necessary info, you could be better discriminating ...'* (Clinical nurse specialist, Oncology)

## 5.15 Concluding remarks

The assessee role itself as a status position must be managed in such a way that it does not interfere with the learning and assessing processes. Important questions for curriculum and assessment designers are:

- How may preparation for, induction into and debriefing after practice experiences be supported and integrated into a holistic approach to learning and assessing?
- How may the practice environment be organised in order to underpin high-quality learning?
- How may assessees be encouraged to theorise the practice experience in such a way that they can expand upon their possibilities for action and identify their needs for 'knowledge', 'skill' and 'theory'?
- How may the assessee role be managed or reconceptualised in order to enhance rather than hinder the quality of the practice experience?
- How may assessees develop *themselves* as professional knowing subjects able to engage reflectively in research based action, thinking, theorisation, debate and dialogue?
- What are the criteria of best practice that integrate curriculum, assessment, teaching and learning?

Resourcing learning and assessment continues to be a major problem.

The questions raised in the above list comprise an ongoing challenge for those responsible for devising and instigating programmes of nursing and midwifery education. The nature of that challenge is multifaceted and complex, and any attempt to produce instant, easily-identifiable solutions is unlikely to succeed. What the questions can do, derived as they are from the irrefutable evidence of observation and participants' perceptions of the difficulties, is to point towards a possible methodology of intervention. Any recommendations derived from this report will need to be extrapolated from the evidence used in formulating the above list and be customised by the educational institution in respect of their own particular circumstances and those of the individual clinical areas used for practice. In the following chapters, the project team have used the data generated by this study to address the questions raised in these concluding remarks, demonstrating how the process of evidence-gathering, *in situ* recording and reflection can promote practice-based learning and its assessment.



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## 6.1 Situated understanding: a conceptual perspective

The task of the practice assessor is to assure the quality of educational experiences and actual competence to practice. Practice is theorised and also uses theory, so when assessors are assessing practice they are bound to examine both theory and practice. These apparently simplistic statements of the assessor's task in fact reveal its complexity. If assessors are to assess theorised practice, they must be confident about what to look for. People do not normally walk around clinical environments theorising their practice out loud in ways that make it immediately apparent to an observer (but see Chapter 7, section 7.3.1). Implicitly, they create theory as they do their work. Outside the practice arena they may refine their understanding, develop their overall stance and construct a coherent theory of their work (see Chapter 7), writing it in readily-accessible texts. Within it, they construct and use their theory of practice by *enacting it*, doing things in response to what is happening around them.

Theorised practice is a theory of possible action under the circumstances, and, given the right circumstances, a theory of alternatives, but it is always a theory lived out in action. It comes into being and is constantly modified as the individual is acting and interacting with other actors (including colleagues and clients) in concrete contexts (ward, community, GP practice, etc.). Theory is not separated out for an observer to examine, it is contained within the practice itself. To assess practice to see how well it is theorised and so gain evidence of practitioners' competence, the observer must see them in action in the full pressure of the working day (Chapter 2) over a long enough time for their theorised practice to become apparent.

Competent practitioners become expert jugglers as they negotiate ways towards situational flexibility, defined here as 'sensitivity to differences in detail between broadly similar situations and ability to actively respond to those differences in uniquely appropriate ways'.

Practitioners quickly learn that flexibility does not mean infinite capacity to bend, however. As they participate in a range of highly varied situations they discover that some possibilities can be actioned more easily than others. The culture of a particular workplace inhibits their capacity to take certain actions and encourages them to opt for others. They are not always aware of this effect of the culture because culturally-acquired attitudes are part of a shared perspective developed tacitly between colleagues interacting with the environment, each other and the problems they encounter. Situational flexibility is learned through being there (Rogoff, 1990) in the clinical workplace where the local culture is embedded.

Situational flexibility is impossible without situated understanding, which in turn can be defined as: 'the *in situ* understanding of the complexity, instability and uniqueness of the situation, calling up instantly a range of values and activating the judgement that enables appropriate action to be taken'.

Situated understanding has judgement at its centre. It is the implicit understanding that enables practitioners to live with and negotiate a way through the competing and often contradictory values they encounter regularly as they 'do' caring. Although embedded in the particular, it nevertheless contributes to practitioners' general theory of practice, a practical theory which anticipates uncertainty in *all* contexts where people are central actors and beneficiaries and structures are constantly being altered. For this reason, it prepares them for unpredictable future scenarios (Anderson, 1993).

Although the terms, situated understanding and practical theory have been used almost interchangeably, they can be separated for assessment purposes. Situated understanding is an element of particular clinical contexts but draws on practical theory to some extent; practical theory involves situated understanding but operates across contexts because it is principle-

driven in order to generate situated explanations to underpin courses of action intended to achieve particular outcomes (see Chapter 8). It is possible to observe situated understanding in the single-context event but it is only possible to assess practical theory after having observed a wide range of events in a variety of contexts. The *principles* derived from practical theory governs *explanations* of what to do in *this* particular situation.

Fieldwork observations confirm what is widely asserted in the literature, that individuals soon cease to be *aware* of their negotiations with the context. How to/how not to behave (how to/how not to practise) in a particular context soon becomes part of the taken-for-granted, held at the level of *non-conscious reflexivity* (Bourdieu, 1990). Until, that is, there is a significant problem. When a problem arises practitioners may make explicit their thinking in response to enquiries posed by themselves or others. In following practitioners in clinical workplaces the research team observed understanding being constructed. It became apparent that not only assessees but all competent practitioners negotiate their way to new understandings as they work in specific contexts. Their practical knowledge is *'constructed dialectically in interaction with the clinical tools that mediate the knowledge in use in [a practice] community'* (Edwards, 2000: 4).

## 6.2 The movement from situated understanding to action in context

In essence, competent practice involves repeated movement from situated understanding to action and back again, through a filter of knowledge and judgement. It entails a continuous process of skill/knowledge transmogrification into situated understanding as practitioners use their judgement to explain and solve situated problems and/or map the structure of the problem for future reference (Figure 6.1).

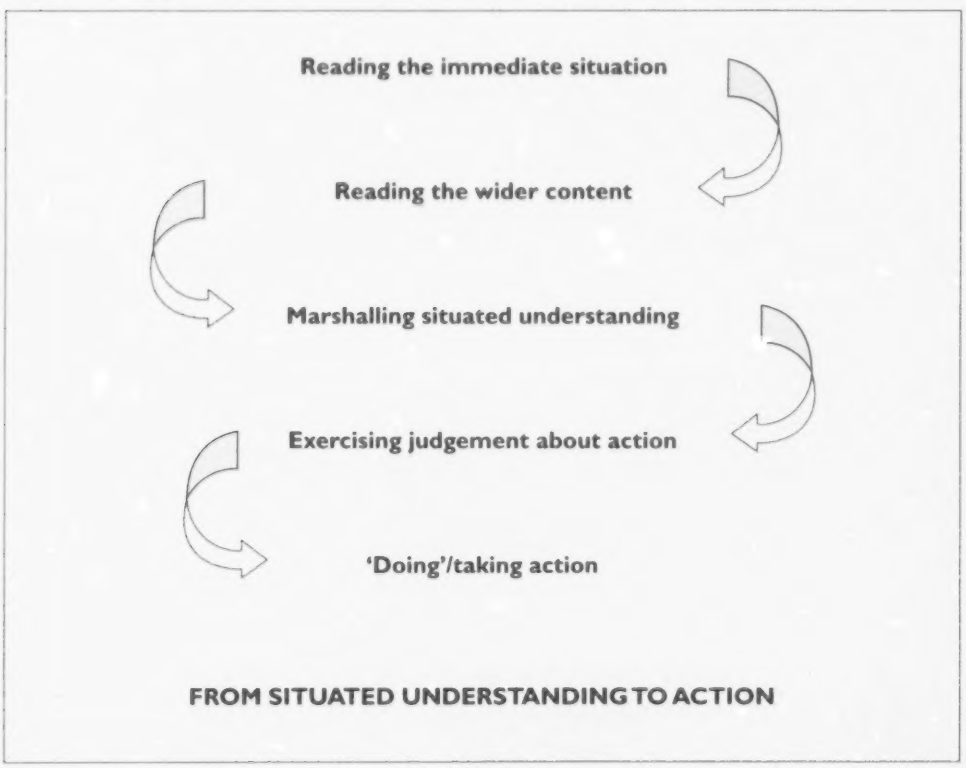


Figure 6.1: Stages in the transmogrification of skill/knowledge into situated understanding and action

The essential ingredients of the process are scanning, analysis, judgement and action.

As the research team carried out observations in practice environments, we came to realise that while competent practice involves repeated movement from situated understanding to action and back again, in a cyclical version of what is illustrated in Figure 6.1, it is not always (or even often) a *simple* process of reading and responding to situational constraints. If it were so, it would be difficult to account for unusual or unexpected actions or understand why a practitioner will occasionally refuse to undertake an activity altogether. Rather, the process can lead either to problem *solving*, problem *mapping* or a blend of both (Figure 6.2).

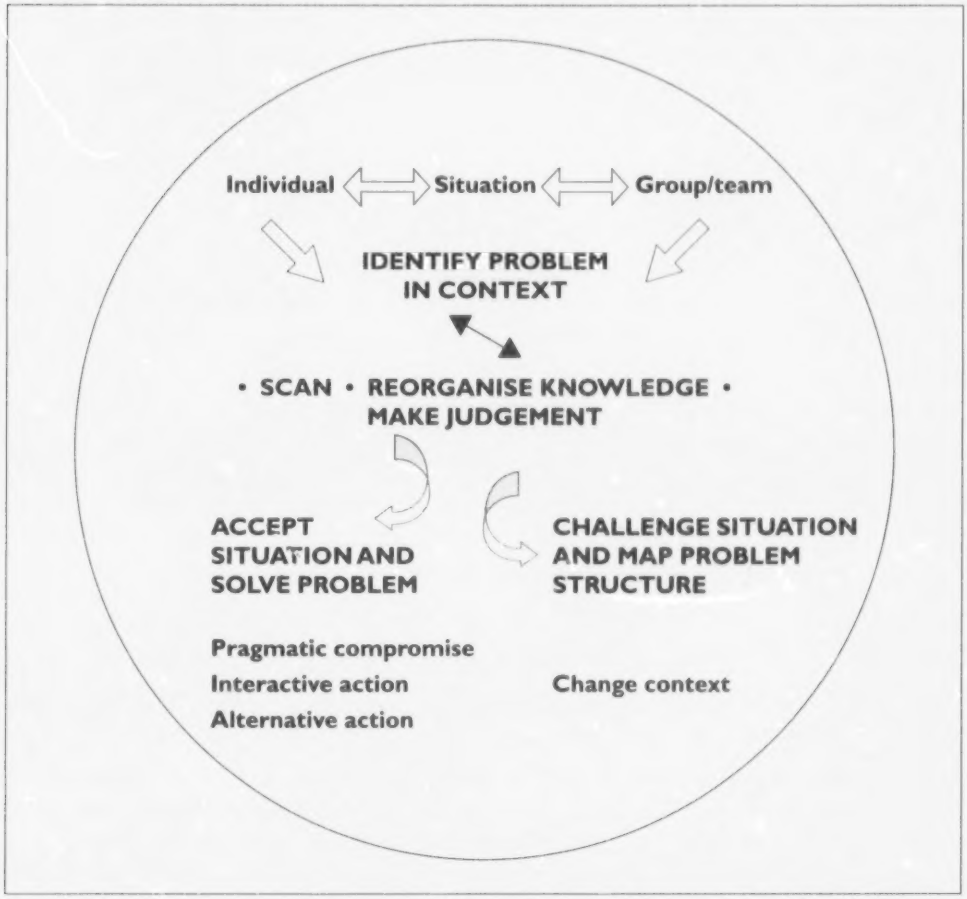


Figure 6.2: The process of moving between situated understanding and action

In this process, mapping is the activity of noting the structure of the problem and placing it within wider experiential and ethical frames. This is done in the split second of interaction with other individuals, clinical teams and the environment and provides the data for judgement which makes further action possible. The judgement may lead to a decision to make a pragmatic compromise and take the best possible action in the circumstances or to act outside previously accepted norms and take alternative action. Or it can lead to action to change the context. The vignettes in Chapter 9 from observations in the workplace offer examples of the process in action.

## 6.3 Focus I

### 6.3.1 Assessing the move from situated understanding to action

How then are the core activities (Figure 6.1) to be assessed? Where is the journey from situated understanding to action most likely to be accessible to scrutiny? How can the interaction with context and assessee's ability to construct their own curriculum (Figure 6.2) be

assessed? How, if at all, is understanding to be represented by the person who understands? Can understanding be satisfactorily represented at all, is it not more a case of enacting it in the context of action? And how is understanding to be assessed in relation to explanation?

One place where understanding is enacted (as indicated in Chapter 7), is in team-based practice or collaborative activity around a shared problem. The successful team obviates the need for representation by substituting a natural, situated, working dialogue of conversation and action. In the natural dialogic context created by problem-focused clinical activity, people negotiate their way through competing agendas and demands, albeit in action as often as words. In the collaborative problem-solving that characterises a team approach, individuals are obliged to consult other members of the 'community of practice' (Elliott, 1993; Lave, 1997; Edwards 2000). This does not mean that they always reach consensus. Often, talking and acting together leads to a better understanding of differences and a reappraisal of the nature of the problem. Individuals test and modify their thoughts/actions in the context of action. In response to others' responses they alter their behaviour, explain their reasons for not doing so or act in a way that amounts to enacted critique. This brings private processes into the public domain where they become observable. The implication is that assessment must recognise action as in-event dialogue and document the 'conversation' embodied in dialogic exchange of practices.

In a process analogous to the one engaged in by managers of medium to large organisations (Boud et al., 1993; Usher and Solomon, 1998), practitioners continually reorganise their knowledge about people and situations and make decisions in the light of the new knowledge. However, the process for nurses and midwives is different from that for managers in one important respect. The pressure on many corporate managers is to conceive of new knowledge as *extra knowledge that supports corporate business axioms*. Despite what is often considerable demand to present a consensual front to the public, nurses and midwives are obliged by their professional Code of Conduct (UKCC, 1992) to refrain from action that is outside their sphere of confidence or they believe is ethically unsound. They can choose to do what is realisable under the current circumstances or decide to seek an alternative on the grounds that doing only what is possible involves unacceptable compromise. Alternatively, they can learn to do both simultaneously. The choice, once enacted, makes evident the theory of practice they are working with at that particular time.

### 6.3.2 Assessment strategies for Focus 1

The first set of conclusions drawn about the task for the assessor from observations of clinical practice, is that they must:

- observe and document the practitioner's action in a large number of separate situations where assessor and assessee are present for a sustained period of time
- map the range of contexts experienced and the response to differences
- map problems encountered
- document actions that represent choices
- identify the strategies employed by the assessee in mapping and responding to points of dilemma.

## 6.4 The assessment of theory and practice together

It is worth digressing at this point to consider how the concept of situated understanding meshes with earlier notions of theory and practice and how these have become problematic for the assessment of practice and theory in practice.

The UKCC's *Interpretative Principles* (1983) and subsequent Board regulations (1993), when discussing the assessment of competencies under Rules 18, 18(a) 33, provided unambiguous

advice that practice and theory should be assessed *'at one and the same time'*. Joint Board/ educational institution validation committees regularly make clear their concern that the relationship between theory and practice should be centrally addressed and that practitioners should be involved in the discussions about it:

> *'Coursework will be assessed in theory and in practice.'*
>
> *'In each semester in which there is a practical placement, progress in the course will be assessed in both theory and practice.'*
>
> *'Curriculum development and monitoring must create opportunities for the collaboration of key individuals and joint working in areas of educational needs analysis.'*

Place assessees in clinical environments where practice is research/evidence-based and:

- undertake audit to ensure that this is effective
- [or monitor such audit as may be undertaken by the clinical team].

The curriculum documents (from schools of nursing and midwifery) seen by the research team, state that both theory and practice will be assessed during clinical placements:

> *'During each clinical placement, the assessee will be expected to demonstrate an ability to construct theoretical concepts and interpret the implications, applying this knowledge to aspects of clinical practice (observed or as a participant).'*
>
> *'The assessee will be able to apply his/her acquired knowledge to problem-solving in the clinical environment.'*
>
> *'The assessee will be able to demonstrate the ability to link theory to practice.'*
>
> *'Care actions will be safe and appropriate at all times. They will be based on facts and principles and utilise evidence from research and literature where applicable.'*

Despite all this, however, assessors, and indeed practitioners as a group, continue to focus on theory as that which is *brought to* and *applied in* practice. It is rarely seen as something *constructed in* or *coming out* of practice. A defensible claim that some aspects of practice are intuitive and not easily made explicit is transmuted into the double-headed premise that theory is about things of no immediate relevance to doing the job and practice has no theory of its own. Practical theory (the situated theory of practice itself which is, in effect, symbiotically fused theory/practice rather than theory *and* practice) has been rendered virtually invisible. Consequently, when assessors assess theory they seek to discover what book knowledge or research information assessees bring to practice and whether or not they employ it appropriately. Some assessors are sceptical about the value of some of this type of theory, many are cynical about the value of other kinds of theory, such as that about the interpersonal and communication.

Perhaps this is accounted for by the fact that many of these theories work with the ideal and appear to ignore the realities of *their* work, workplace and context:

> *'It's very easy sitting in a classroom saying "well, in an ideal ward, this is what should happen" but actually putting that into practice against all those cultural things – plus the resource issues – it is tough.'*
> (Practitioner assessor, ITU)

The theories are, by this reckoning, largely an academic exercise:

> *'The theory is very valuable and interesting but nurses are asking for something really to combine the practice with the theory … something which would match their actual roles much more than just the academic theory.'* (Post-registration assessee, Rheumatology Masters programme)

The situation is, then, that theory is rhetorically valued in documents but largely ignored by clinical assessors when they fill in the documents. *De facto*, theory becomes inauthentic *'other'*, separated from practice, while practice is *'what I/we do in the "real" world'*. Situated theory is rendered invisible. There is clearly a case for assessing practitioners' knowledge and use of research and similar theory, but this may need to be done in ways that recognise the processes involved in transforming pure theory into applied practice.

## 6.5 Focus 2

### 6.5.1 Assessing the move from 'now', through 'alternative now' to 'future' competence

Observations in clinical practice environments suggest three stages in practice competence. These are not commensurate with levels, as explained below, because – as far as the research team could determine – safe and effective practice requires them all. Each dimension provides an alternative perspective on practice but all are necessary for competent practice. The dimensions are:

- perspective 1 – 'now' competence – competence for similarity
- perspective 2 – 'alternative now' competence – competence for difference
- perspective 3 – 'potential future' competence – competence for difference.

To reiterate the point about levels, assessors are able to differentiate practice competence conceived in terms of competence to practise effectively and safely under the current circumstances (now competence), to practise effectively and safely but in a way that differs from the norm when the situation demands it (alternative now competence), and to practise safely and effectively by challenging the circumstances which constrain preferred action in the current context while actively working towards change in those circumstances (future competence). But this is a conceptual differentiation rather than mutually exclusive types of behaviour.

The model of learning set out in Figure 6.3 is new, in so far as it is derived directly from observation and interview. It is founded on the claims of the majority of research informants that they were unable to detect levels in practice. In fact, as far as they were concerned, a competent practitioner was a competent practitioner. It is also based on extensive first-hand observation of practitioners moving between doing practice in routine ways, making choices in unusual situations and making interventions in the context to improve the possibilities of health care in the future. It is, therefore, a model which is *drawn out of evidence* rather than an *a priori* model.

The difference here is between a model of practice learning as progression through a series of levels (borrowed from academic learning and presented in many nursing and midwifery assessment documents) and as a broadening of perspective (the model presented here). This difference is spelt out most recently in the statement by Stronach (2000) presented to the Summerhill Tribunal in the case of Summerhill versus the Department of Education and Employment. Although written to show the difference between an authorised concept of learning and the unorthodox practice in a particular school, Stronach's statement summarises the relationship between learning and development in a way that is applicable wherever the learning takes place. It contrasts learning perceived as linear and progressive (moving *forward*) with learning which is discontinuous and transformative (i.e. it changes and broadens the perspective of the learner through an internalisation of learning from experiences).

Observations in the workplace made it apparent, then, that most assessors had considerable difficulty detecting levels in practice; most of those who tried to assign a grade had abandoned their attempt. There was an intuitive recognition that competence requires ability to operate in different ways in response to the context and the opportunities and constraints it presents. Assessment, therefore, might more validly differentiate practice in terms of increasing

breadth and ability to operate simultaneously with parallel processes. Visually, this differentiation can be represented as shown in Figure 6.3.

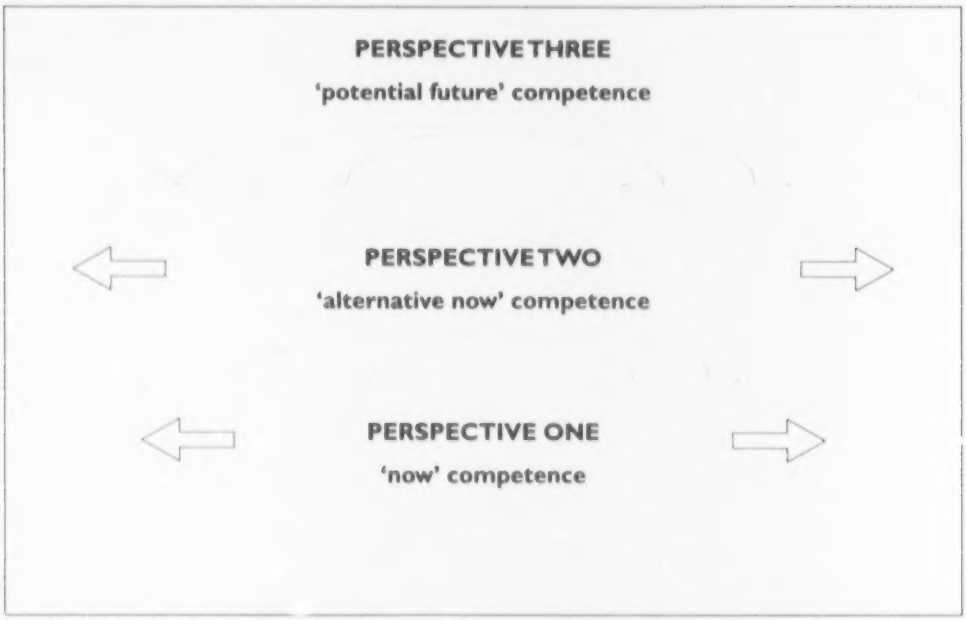


Figure 6.3: Differentiation of practice in terms of increasing breadth and ability to operate simultaneously with parallel processes

Many pre-registration nursing/midwifery qualifications, including those for diploma and degree programmes, use academic criteria to differentiate levels in practice. Post-graduate programmes rarely assess practice levels at all. There is an evident need to improve assessors' ability to recognise different levels of analysis in assessees' practice.

### 6.5.2 The need to reconceptualise levels in the assessment of practice

If action itself is a form of dialogue, then contingent on an approach to assessment as part of the process of in-event dialogue is a reappraisal of the nature of development.

During the life of the project, the researchers found themselves re-appraising the hierarchical apprenticeship model promulgated by Dreyfus (Dreyfus 1981; Dreyfus and Dreyfus, 1986) whose concept of novice to expert, expanded by Benner (1984), has become something of a mainstay for developing the nursing curriculum over more than a decade. That period has been dominated by a preoccupation with the relationship between theory and practice (Lublin, 1985; Treacy, 1987) and the desire to produce a balanced curriculum which ascribes appropriate weighting to each of these components, supports one with the other and emphasises whichever is more appropriate at that part of the programme, while seeking to achieve a seamless integration between them as halves of a developing whole.

Hierarchical and linear models emerged from Benner's early continuum to later collaborative work (Benner and Tanner, 1987). The higher education or 'technical rational' model with competence at its apex was described by Davies (1991), who saw the acquisition of clinical knowledge as dependent upon a hierarchy, the base of which comprises the scientific body of knowledge from which theoretical models can be derived to inform practice.

Throughout this period, a concentration of activity developed around the concept of the hierarchy of competencies; Schön (1987) extended this to elaborate the link between competency (apprenticeship) and emergent professionalism: 'practical competence' becoming professional only when its inherent problem-solving potential is grounded in *scientific* theory.

One problem with the traditional hierarchical or linear model is the differentiation it has perpetuated between theory and practice, and the arbitrary sequencing of that relationship. Skeet (1990) acknowledged the problems encountered in a traditional nursing curriculum in allowing theory to inform practice. The problem is not with the relationship between theory and practice, but more in its structured representation and the ensuing rigidity of sequencing. This becomes evident when account is taken of a parallel view which extends the hierarchy or continuum beyond the point of competence achieved, to one where practice and reflection *together* form an integral and essential process in the development of expertise and of professionalism.

The importance of reflection as a component of personal and professional maturity and in providing an integrative function between theory and practice, has long been recognised, with seminal work by Friere (1972a; 1972b) conceptualising praxis as the link between reflection and action which is necessary to transform a given situation in the workplace. Reflection does not occur automatically with competence, but as a constituent of developing expertise, and is something which the accepted expert is not always more proficient at achieving than a comparative novice (Wickens et al., 1992). In describing the essence of professionalism in the inconsistently differentiated and ill-defined nature of its practice, a number of researchers call for flexibility, imagination and the inclusion of intuitive and exploratory instincts in using both theory and practice to promote learning, understanding and professionalism (Styles, 1982; Agan, 1987; Smyth, 1988; Benner and Wrubel, 1989).

It is this emphasis, which traditionally has been seen to distinguish nursing and midwifery *education* from its counterpart *service* provision, contributing to the perceived theory-practice gap (Fretwell, 1982; Melia, 1982; 1987; Chua and Clegg, 1989). Variously described as a dissonance or disalignment between the two aspects, it is a cultural divide which is seen as possessing a certain inevitability given the very different philosophical bases from which they may have emanated (Walker and Norby, 1987).

Certainly a hierarchical, competency-driven, task-focused approach has been used punitively and mechanistically to predict the cost of providing care and the minimal staffing (skill-mix) possible to achieve this. By comparison, educative approaches go beyond the mastery of tasks, promoting a questioning, searching attitude (Hockey, 1993) and encouraging the reflection needed to convert experience into learning (Boud et al., 1985).

The impetus for a challenging educative approach is timely. Nursing and midwifery have made enormous progress in establishing their own independent and autonomous discourse. What they still require are the tools necessary for deconstructing that discourse in order to enhance its efficiency and the potency of its professionalism.

Competent practitioners from any profession are capable of reading situations and recognising them as simultaneously like others and yet unique (Lave, 1990; 1993; Lave and Wenger, 1991). Nurses and midwives develop competence by building a repertoire of cases from their previous experience in contexts of action, enabling them to evaluate evidence from the current situation and compare it with analogous situations (Chapter 8; and Bedford et al., 1994). They learn to practise by developing range and repertoire in experience which facilitate imaginative leaps. This signifies a shift from understanding learning as a vertical climb to a specific goal to a horizontal model where learning is an expanding, broadening experience that draws upon and adds to prior life and working experiences (Solomon, 1999).

Development, then, is neither linear nor hierarchical. Instead, it is iterative, interpretative and hermeneutic, involving critique and requiring the questions, 'why?' and 'how else?' The concept of levels, which assumes both linearity and hierarchy, is inappropriate. Additionally, because the repertoire is case-based and developed from what was done in the hurly-burly of real practice, it incorporates practical compromise in which one set of values is, for the time being, prioritised over others.

Practice is characterised, therefore, by best possible action in the circumstances, and is the result of in-event decisions about which values should be prioritised *on this occasion*. Best possible action in the circumstances may look like an earlier stage on a hierarchical model; the research team's observations suggest that it is the outcome of judgement in complex situations and marks a high degree of competence.

#### 6.5.2.1 Broadening perspective

*'The location is a surgical ward in a general hospital. Nurses are organised in two teams – 'yellow' and 'green'. Yellow team consists of a charge nurse, a senior sister, three staff nurses, three care assistants and a ward clerk; green team has a senior staff nurse, three staff nurses and four care assistants. On this occasion there are four qualified staff (two D grades, one E grade and one G grade) and four care assistants. The ward is managed today by the senior sister, Maria.*

*The ward cares for male and female patients in six bays with four beds in each bay. The sexes have separate bays. The most common activities undertaken in a typical day include wound care, catheterisation, assisting patients to sit up or walk, providing information to patients and family (face-to-face and over the telephone) and co-ordinating the work of other professionals.*

*The nurses' station in the yellow team area is informal, with a small table on which there are in-trays and box files; a second table alongside has a computer. The atmosphere is friendly (people share banter and jokes, both nurses and junior doctors address each other by their first names) and appears unrushed, although after a while it becomes evident that the rush is carefully managed rather than absent. There is a small table and easy chairs a little further away in an alcove where there are professional magazines and nursing care texts. On the walls notices set out the aims of the nursing teams and is a notice board with information about a range of programmes of education. Some of these are provided by the nearby university on its campus and some by the trust within the hospital.*

*Tanya is a staff nurse completing a part-time top-up degree. She has been working on this ward for three weeks. Her assessor, Maria, herself a graduate nurse, has completed a six-month assessor-training programme at the university.*

*Seventy-year-old Mrs Sharp, who has been involved in a road accident and has what appear to be extensive but not serious surface injuries to one arm and one leg, is having a dressing on her leg replaced by Tanya. Tanya chats with her whilst undoing the old dressing and they share a joke about 'not being able to go skateboarding again for a while'. Tanya is soon joined by Maria who assists with the last stages of removing the bandage. As she does so, Maria feels the patient's knee, checks with her that the wound has been X-rayed and wonders aloud whether a stitch might be necessary. Tanya reassures Mrs Sharp that this will not be a complicated process. Maria then tells the patient that she is going to check with the doctor about the stitch before the new dressing is put on. Maria and Tanya both retire from the curtained bed area.*

*Outside, beyond Mrs Sharp's hearing, Maria tells Tanya that she suspects the kneecap is damaged. 'It didn't feel right when I put my hand on it and moved it about, and you can see in the wound and it looks sort of strange. I'm going to ask James [one of the junior doctors] to check'.*

*Maria then suggests to Tanya that she goes back to Mrs Sharp, 'Go and have a feel round Maude's [Mrs. Sharp's] kneecap where the wound is, it's badly shattered. Feel the other kneecap first, find out what a normal kneecap's like, then compare it with the other one.' Tanya then seeks out James, who examines the knee, agrees with Maria that there is 'something not quite regular' and arranges to send Mrs. Sharp for an X-ray.*

*Maria and Tanya complete the dressing, telling Mrs. Sharp what they have been doing and explaining what is likely to happen next. In the course of doing the dressing Tanya has an opportunity to feel both knees. The X-ray is taken half an hour later and confirms that Mrs Sharp's patella is shattered into three. Tanya is asked to give her this information and the news that surgery is being arranged for the next day.*

*Maria is involved in a series of management activities while Tanya goes to work with another nurse who is about to catheterise a male patient, having been asked to do so by Maria. As they are getting the patient ready they discover his urine bottle is full and discuss whether this indicates that he does not need a catheter. Tanya suggests they check with Maria when the fluid level was last checked, and discovers that it was empty 10 minutes earlier; she returns to tell the patient that catheterisation is not necessary.*

*Tanya rejoins Maria who is on the phone to the ambulance crew who will be transporting a patient to be discharged that day. Maria tells the crew member she is speaking to that the patient will be ready for transporting in 15 minutes. After putting the phone down she says to Tanya, 'A little white lie, I'm afraid, but if you tell them it's soon and leave them discretion they'll arrive three hours later. Better to have them turn up and wait around for 10 minutes or so than have them turn up at four o'clock [four hours later].'*

*On this occasion the ambulance crew arrive almost immediately. 'Oh, heavens, that's caught me out!' Maria asks them to assist the patient to bag his notes, medication, X-rays and personal possessions while she calls James to see another patient. While waiting for the doctor she says to Tanya, 'If you keep [the ambulance crew] busy it doesn't seem like they're waiting.' Next she says, to the researcher while Tanya is still there, 'I have to decide, shall I bleep James now and risk an earful for calling him twice in 10 minutes, or shall I risk waiting, in which case he might not be here in time for the discharge. What I've decided is that I'll give him 15 minutes' and then bleep him again if he's not arrived.' The doctor arrives in just over five minutes and Maria and he joke about work pressure, 'I've forged your signature James to save you time'. She hasn't really!*

*Later, Maria and Tanya take a coffee break together when they discuss the knee incident, and Maria's strategies for prioritising activities.'*

(Vignette 1)

Although unquestioning application of context-independent knowledge and slavish implementation of skills as routines are marks of the novice (Dreyfus, 1981; Benner, 1984), competence is not a *simple, once and for all progression* to some higher order set of skills and knowledge. The competent practitioner in the vignette used different types of skill and knowledge *together* and had the confidence to work *across* so-called levels. She remade her skill and knowledge in context; she did not slavishly follow procedure but actively critiqued it, perceiving options, exercising judgement and making a choice. She has learned through her fingertips and used that fingertip knowledge. She has also developed sensitivity to the feel and colour of skin, the

level of a patient's breathing, and signs of anxiety and discomfort that indicate a patient may have problems. She scanned the situation for all those things and made a judgement that something was not as it should be. She decided not to act in a now context but an alternative now one. Motivated by her situated understanding, she drew on her practical theory and made a judgement made explicit in her action in calling the doctor to re-investigate what had previously been 'closed'. This required competence from several perspectives at the same time, as well as movement back and forth between perspectives.

### 6.5.3 Assessment strategies for Focus 2

Valid assessment will examine assessees' ability to demonstrate all three types of competence, not by assessing them at first one level then another and another, but by examining their overall activity. (Range and variety will have been dealt with as a Focus 1 activity.) Because practitioners are only fully competent if they are able to practise for the situation as it is now, think about how it might have been other and prepare for the new, and are unsafe if they are unable to do *all* these things, assessors need to be able to identify, collect evidence about and analyse the full range. It is likely that assessors will only become competent at these research-like activities if they have done them in their own practice. Paradoxically, perhaps, the main strategies for development must engage potential assessors in assessing *their own* practice. The strategies would be, then:

- education that offers potential assessors the opportunity for guided *in situ* analysis of their own practice
- education that provides potential assessors with experience of constructing a research case study (not to be confused with a clinical case study (Ragin and Becker, 1992; Stake, 1993) in which they can picture now, alternative now and future competence as components of the same ability to practise competently
- education that provides assessors with the opportunity for dialogue about collecting evidence and analysing different types of competence assessment
- education that enables assessors to look at this evidence in terms of subsequent curriculum building.

The education would be intended to equip the assessors with confidence to identify:

- the biomedical and fingertip knowledge they have employed on a given occasion
- the knowledge of particular people/professionals they have drawn on
- the aspects of the context (including the team or interaction context) which affect what they have done and how they have done it on a given occasion.

Education for Focus 2 would interweave with that for Focus 1 by preparing assessors to look critically at individual behaviour, team behaviour and interaction between the two, and evaluate the extent to which practice requires 'fit within' a context or challenge to it.

A key task for assessors remains how to document development conceived of in terms of a broadening of experience and not as linear progress. One answer may lie in the methodology adopted by the research team, described in Section 6.6.

## 6.6 Creating effective structures for 'mapping' movement towards analysis via action, context, dilemma and choice

Before being able to evaluate assessors' competence to assess, the research team had to find ways of mapping how and with what degree of effectiveness assessees moved from situated understanding to action. Practitioners were observed in action in a wide range of situations but with a main concentration on complex situations which *'lend themselves to rich*

*possibilities of knowledge productivity'* (Beckett, 1996). As complex situations they offered the opportunity to observe assessees where the problem potential was relatively high, and because so many typified the *'brevity and fragmentation of practice interaction'* (Mintzberg, 1989), the team had to work closely for sustained periods with individuals to access their situated theory. The following example, written up from observation notes as a micro-vignette, tells a typical story.

> *'The general/genito-urinary surgical ward is perpetually busy with four medical teams, daily theatre lists and emergency admissions. The staff feel over-stretched affording their patients of both sexes adequate care, observation and dignity in the separate bays and side-wards. The assessee (halfway through his adult branch programme) now has his third assessor in this single placement. His 'preliminary' interview occurred in Week 3 and his mid-point assessment is deferred indefinitely. He needs this placement to acquire a range of clinical skills including oral and intramuscular drug administration, but the pressure of work has repeatedly resulted in single nurse administration while he has maintained a basic level of care for the remaining patients. Today proves no exception.*
>
> *Patients for surgery arrive before their beds are vacated by those awaiting discharge and the two emergency admissions are female when the only empty beds are in a male bay. The assessee moves beds and possessions accordingly, and as people go home, washes furniture and makes up the beds for the afternoon theatre list. In between, he assists patients to wash, where he can manage single-handed helps post-operative patients to sit out of bed, performs nursing observations and notifies trained staff when intravenous infusions require changing. Where pre-medication or post-operative analgesia is required, he is never free to be involved. His practical learning objectives are not being achieved and he fears this will affect his ultimate success. His sole ambition now is qualification before he leaves nursing.'* (Vignette 2)

Had an assessor been present, they would have had informal access to the shadowed nurse's situated understanding (or practical theory). They would have seen it being simultaneously shaped and put into practice in relation to specific clients and been able to assess its appropriateness in the particular situation. They would have seen, for instance, that the assessee was developing a theory of nursing as keeping patients comfortable, as this first extract from a fuller version of the researcher's field-notes shows:

> *'Theory A*
>
> *The assessee continues to attend to the needs of the men in his bay, helping them to wash and, where he can manage it himself, getting them out of bed and making the beds with fresh linen. The charge nurse joins him briefly following the drug round and together they wash and turn the confused elderly man, the charge nurse being called away at this juncture to attend to the patient in the side ward who requires pain relief. The assessee meanwhile has to wash down the vacated beds and make them up with clean linen to accommodate patients for the afternoon theatre list who are beginning to arrive.'* (Vignette 3: extract 1)

The assessor would also have seen that the assessee was extending this theory to include a parallel theory of nursing as moving people and resources to locations where they can be attended to by others, as a second extract from the same notes shows:

> *He checks and logs belongings, washes out bedside cabinets ready for their use and gives them a quick description of the ward layout and likely sequence of events. The anaesthetist arrives on the ward to see these patients pre-operatively and prescribe their medication, but again the assessee is unable to accompany him or be involved with administering any of these drugs as he is fully occupied providing basic care for patients in his bay He completes some of the nursing observations due and begins the nursing notes for patients admitted that morning, but this is taken over by the charge nurse who asks him to go to the hospital pharmacy and collect some drugs for patients waiting to go home. Apparently all the porters are busy now taking meal trolleys to the wards and there is no-one else available to do this.'* (Vignette 3: extract 2)

The assessor would have been able to discuss these two theories with the assessee and examine (a) how well he was able to work within potentially conflicting discourses and (b) the values he demonstrated in doing so.

Because practical theory demonstrates situated understanding, assessors must look at both action and the context in which it occurs. The researcher was able to document the context itself by constructing a narrative account of the working day with all its material constraints:

> *'The nature of much of the surgery undertaken on this ward means that there is a constant struggle for the available staff to meet their patients' basic needs for hygiene, dignity and privacy regarding bodily functions. The nursing care of the female patients is largely undertaken by the two female auxiliaries with the junior sister able to provide trained expertise for some of the more intimate invasive procedures.*
>
> *Both nursing auxiliaries are long-serving experienced members of the ward team and have been accepted as capable of undertaking a wide range of nursing care ... They have developed a routine way of working and appear to have a considerable amount of autonomy: deciding who will get out of bed and when, and what level of assistance they are prepared to give with any activities the patients are required to perform.*
>
> *The morning's activities are interspersed with doctors' rounds, each time involving the charge nurse and each resulting in patients being discharged. The charge nurse takes responsibility for this - arranging porters, transport and drugs to take home.'* (Vignette 3: extract 3)

To create appropriate conditions for collecting and assessing such data, the researchers needed:

- introduction to and prior experience of this type of observational activity
- time to shadow the assessee for a sustained period of time
- freedom from clinical 'distractions'
- time immediately following shadowing exercise to note or add to observations made during the exercise
- preparation in methodology for accessing (interpreting) and using this type of data.

It seems probable that assessors will require similar circumstances, or they will not be able to make what seem to constitute valid assessments of assessees' competence, without cost to the quality of care they give or to their own wellbeing. But, as the *evidence* in this report

 demonstrates, much remains to be done to ensure valid and reliable assessment of practice in practice.

## 6.7 Shortcomings of current assessment procedures

As previous chapters revealed, formal structures for assessment of practice have failed to deliver a system that identifies situational understanding. The way these structures have been implemented has disintegrated the practitioner/assessor role and made the job a huge additional burden for practitioners. Most practitioner-assessors met their obligation to hold three formal assessments with some difficulty because their clinical environments were under-resourced. Put another way, assessors were simply *too busy* as carers.

A considerable amount of official assessment of pre-registration assessees is unreliable for the following reasons:

- it occurs at different points in the practice schedule for different assessees
- it happens a different number of times for different assessees
- it fails to provide some assessees with an opportunity for analysis and forward planning
- it does not draw on evidence directly available to the person undertaking the assessment role
- it is not supported by in-practice assessor discussion about criteria.

The assessment of post-registration assessees was also unreliable for the majority undertaking programmes to develop a specialism or preparing a dissertation for a Master's-level award. Assessment was normally carried out by someone outside the practice environment, using written evidence because there was no specified in-practice assessment at all. Most assessment of post-registration assessees is invalid with respect to practice because:

- it fails to evaluate how well – or even whether –the assessee has situational understanding
- it assesses representational competence rather practical competence.

## 6.8 Structures for improving practice assessment

### 6.8.1 Recognising how assessment of practice is actually done under current practice conditions

While formal assessment does not 'deliver', there is evidence that – provided it is supported by an appropriately resourced infrastructure – informal assessment can do so; it happens anyway and it simply needs to be systematised and supported.

Currently, assessment is actually carried out by anyone who happens to find themself working with the assessee.

> **Nurse:** *'We've got a student on our ward who – he's been, he's halfway through, no he's near the end of his first year now and he's very insecure about doing anything, very unsure what he's doing and it's noticeable that he's a lot less confident than another student we've got here who's been doing the same course, the same amount of time, and I don't know if it's just personality differences but he doesn't want to ask, he's scared to ask, he's scared to do anything, or the fact that she's just picking it up a lot quicker and become a lot more confident.'*
>
> **Interviewer:** *'Are you part of the team that's assessing him?'*
>
> **N:** *'No.'*
>
> **I:** *'You're not, not even indirectly?'*

N: *'Not really, no. I suppose I …'*

I: *'So you're getting team support but he's not?*

N: *'I guess I am in that if he works with me I might report back to the nurse and tell the nurse how he's done with me that day.'*

I: *'But its left to you to make that decision?*

N: *'Yes, its left to me to make the decision.'* (Nurse assessor)

The nature of practice means that practitioners move rapidly from one task to another, fitting in things as and when possible. Budgets, employment regulations and personal roster preferences mean that particular staff are present in the practice environment on one day but missing the next; and patients and other professionals often need immediate assistance. This mean that practitioners regularly leave what they are doing to do something else, returning later at some unpredictable time. Almost inevitably, assessment becomes fleeting and impressionistic and, because it is snatched, peripheral and in-the-practice-event, seen as not 'proper' assessment.

Although informal clinical team member assessment contributes centrally to the overall 'feel' around which official comments are eventually constructed, practitioners are given little or no support to enable them to co-ordinate individual and incidental evidence into a valid and reliable 'triangulated' evidence base.

Within the context of the practical problems any practitioner has in organising their clinical activity to be alongside a particular colleague for sustained periods, it is not surprising that most contact is fleeting and impressionistic. Conversations are often disjointed, with a focus on getting work done rather than assessment. Interactions with secondary assessors are driven not by a quality development agenda but by a task-survival one (Chapter 2).

The imperative is to remediate a knowledge or skill deficit sufficiently to enable the current task to be completed. The assessee is 'taught' by being given information or having an essential skill demonstrated but this 'teaching' is rarely followed up with a formal assessment of the learning. This would require a more systematic approach than is currently evident. In the meantime the collection of detailed evidence is a low priority for practitioners and assessment practices continue to construct assessment as the piecemeal collection of impressions formed during casual encounters.

### 6.8.2 Supporting assessment of 'now' competence

The urgency of much clinical work means assessors and supportive non-assessor colleagues are constrained to give present care a primacy over future care. But when they do have time to work with assessees, they tend to engage in information-giving, role-modelling and teaching by showing – all forms of teaching rather than assessment.

They clearly see it as their job to ensure assessees can cope with the immediate situation and satisfactorily complete the job in hand. Current assessment practices foreground reactive competence; competence in the circumstances and under the current conditions. Nursing and midwifery educators' rhetoric espouses the value of reflective practice and places it at the centre of written, portfolio-style assessments. But reflection is given little emphasis *in practice*, where the spoken equivalent of the portfolio – practice-embedded thinking out loud – is hardly ever seen and alternative courses of action are only occasionally discussed. And, because it is difficult to do in busy situations, reflection that incorporates critique and potentially enhances future competence, receives even less attention.

The majority of practice assessment, whilst not actively discouraging critique, does little to encourage it. Assessment practices construct the achievement of pre-specified outcomes as a priority and relegate exploration of the judgement and decision-making processes that led to that outcome to a less central position.

What we have for the most part is a situation where assessees are left to self-monitor their learning and develop – without training – their own critique of it, or depend on their activity being noticed (although this word suggests something rather too deliberate) by a passing colleague. While assessees' assumptions are challenged and understanding examined if they come into contact with a colleague who is, serendipitously, currently concerned about the same issue(s), little *systematic* assessment occurs and thus there is little *planned* educational development.

It is unusual for colleagues to have prior knowledge of assessees' earlier learning because it is rare for such information to be systematically transferred from practitioner to practitioner. Thus, what is created is a set of assessment practices which:

- focus primarily on what is missing (the deficit)
- attend less actively to what is there (the current or currency)
- pay little attention to what has been successfully learned (the value added).

The first point is made explicit in the set of programme documents from which the following extract is taken.

> *'The student will (a) re-visit the professional profile to ensure any deficits have been achieved, (b) re-visit any current action plans to ensure any deficits have been achieved, and (c) bring the professional portfolio up to date.'*

### 6.8.3 Supporting assessment of 'alternative now' and 'potential future' competence

If practice-based assessment is to move beyond deficit-remediation to include critical analysis of action in context and assessees are to be given credit for learning and understanding, not just performance, assessors need to be simultaneously 'of' and 'not of' the practice environment. Wearing a carer/assessor hat they are in a position to see and analyse with assessees while 'doing' care and able to enter into a situated dialogue through the actions they opt for and through which they negotiate a present-time (now) set of practices. This is interactive decision-making leading, paradoxically, to temporary closure; to a practice that gets the job done. Wearing an assessor/carer hat (the first hat turned back-to-front so that care, while still integral to the total hat, is not the aspect by which it is recognised) they are released from responsibility for the pragmatics of immediate action. They can then help assessees analyse the now in relation to its resources, management structures, decision-making and communication structures (all aspects of the current that constrain present action) as well as engage them in dialogic interactions that work towards non-closure and the avoidance of compromise.

This systematic role-switch would make it possible to have dialogue as it was intended in Phillips et al. (1994), as a set of conversations about future-orientated alternatives conducted through both discussion and action, or – in a different vocabulary – discourses and practices. The focus clearly then becomes a focus on judgement, decision-making and action as an integrated set of practices-cum-discourses.

## 6.9 Conclusion

Informal assessment is central to the assessment of practice; without it there would be no assessment. Yet those who do it are not currently trained to evaluate learning, only outcome. They can say how assessees are doing but not how well equipped they are to learn from their experience and incorporate that learning into future practice. In-practice assessment assesses competence for the service as it is now but fails to assess competence to work flexibly within the changed service as it will be tomorrow and further into the future. This is not to argue that assessment in the practice environment cannot do that, but that if it is to do so then it must have structures for bringing informal assessment into the mainstream.

Safe, competent practice in the current situation, achieved through filling deficits in skill and knowledge, will almost certainly be unsafe in the future when circumstances and options are different. Competent practitioners must, of course, be capable of envisaging alternative actions for present circumstances, making judgements about which alternative to adopt and acting decisively – and all in a split second. But if these practitioners are to provide safe and effective health care in the future, their competence must include the ability to envisage alternative circumstances too.

Currently, a large part of the evidence used to assess experienced practitioners' development and pre-registration assessees' competence officially is in the form of written reflective accounts of practice as presented in journals and portfolios. In pre-registration assessment, further evidence is taken from conversations and schedules completed during preliminary, medial and summative placement discussions between assessee and assessor. However, the majority of assessment is done informally by people other than the designated assessor while working alongside the assessee. The evidence they use is embedded in the situation and reveals knowledge and understanding indirectly. It is natural evidence in the form of informal exchanges about patients and snippets of conversation, captured on the move, about the assessee's thoughts and feelings. It is also evidence that comes from direct observation of practice; it is virtually unmediated.

The research has revealed an absolute need to consider the assessment of practice in its *cultural context*. Practitioners' competence in giving care is constrained by the expectations of the team they are working with, the resources available and the nature, quality and accessibility of the decision-making structures in the clinical environment.

Practitioners are immersed in their particular work environment and have internalised the set of practices created by the culture and habit of that environment. Many of these are informed by a pragmatic theory of how to achieve the best for the patient under the circumstances, learned experientially rather than through texts. It follows that analysis cannot be an add-on activity learned through out-of-context coursework. It can only occur where an analytical approach is itself part of the workplace culture.

What is required is a movement away from piecemeal, *ad hoc* assessments that are added together at some point without much intentional analysis (an approach that accredits quantity) to assessment based on in-depth analysis of extended practice events. This will need to become embedded in the culture of the workplace. Just as the knowledge that informs practice is invisible once it has become a taken-for-granted part of the practice culture, so the culturally-embedded thinking that informs assessment is invisible. The necessary cultural change can, by definition, only be achieved within the culture.

The research also indicates a need for assessment co-ordinators whose role is to ensure the structure of the workplace permits assessor-practitioners to be in regular contact with their assessees over long periods. It points to a paramount and immediate need for infrastructures and remunerated roles in the workplace to ensure valid and reliable assessment, without which the possibility of future safe practice is at risk.

Observations of practitioners in the workplace have shown that practice assessment is rarely the sole, or even the primary responsibility of designated assessors. Often, it is carried out informally and indirectly by the whole clinical team. It has also shown that because clinical environments are often insufficiently resourced to permit sustained dialogue, assessment becomes piecemeal, indirect, *ad hoc* and opportunistic. This severely limits opportunities for *in situ* analysis of the kind discussed.

## 7.1 How the portfolio is most often used

Bedford et al. (1994) and Phillips et al. (1994) proposed that reflective understanding should be developed through dialogue around portfolio evidence of practice. Schostak (1985; 1991) argued separately for the narrative construction of cases and for recognising the relationship between stories and action. Phillips (1987; 1988; 1994) has written about the role of speculative and narrative talk in shaping understanding of experience. Winter (1991) and Cox et al. (1991) have advocated journal writing and narrative for post-event reflection. Elliott (1991) and Schön (1987) has argued that professional practice is learned and developed through 'doing' and 'reflection on doing'. Even Mintzberg (1989) and Gott (1989), who pointed out that doing does not necessarily have to take place in the practice environment and that some necessary skills and knowledge may be rehearsed outside it, would not disagree with this general thesis. All assumed an integral relationship between practice and thinking about practice (reflection) and portrayed practice as situated activity.

Elliott, interpreting Giddens' work on structuration and discursive consciousness, argued that agency is constructed in communities of practice and that: *'system change involves the restructuring of practical consciousness through the reconstruction of their store of mutual knowledge'* (Elliott, 1993:182).

Phillips et al. (1994), drawing on the notion of dialectic (Bhaskar, 1993) and dialogic (Bakhtin, 1981) made a plea for intervention in this restructuring process. Informed by Bhaskar's and Bakhtin's argument that struggles with anomaly, dilemma and contradiction often motivate change, and by interviews with practitioners that confirmed this, they argued for assessment as a process of dialogue and critique of evidence. At the time, they proposed the use of portfolios of evidence as a focus for dialogue.

Since 1997, the extensive fieldwork undertaken for the current research has caused us to reappraise these earlier views. While this fieldwork indicates that portfolios have proved valuable educational tools in a number of ways, they have become constructed through use in ways that limit their effectiveness:

- as a valid record of competence in practice
- as a trustworthy account of the writer's thinking
- as a focus for dialogue about contradictions, dilemmas and choices.

The current research indicates that observation of practice in the practice environment offers more valid evidence of 'thinking in action' (Chapter 6). The portfolio as an assessment device tends to direct attention away from the situational understanding, negotiation and judgement which play a central part in competent practice and emphasises instead the documentation of 'successful' practice and presentation of evidence that action was well informed. This chapter considers the portfolio itself, how it has come to construct reflective practice in terms of a weak form of reflection, and how – in several cases – there has been movement beyond this.

### 7.1.1 The portfolio as a place to display achievement

Since the introduction of diploma-level education a substantial part of the assessment of competence has been carried out through the use of portfolios in which learners make public their understanding. Portfolios were designed to provide an evidence base for dialogue between colleagues, including assessor and assessee. They were also intended to provide a location for practitioners to collect and reflect on examples of practice.

The almost complete absence of guidelines indicating that portfolios can be used to analyse practice in relation to the constraints of the situational context suggests that within many programmes they are primarily intended to be used to capture competence to handle current situations. Consequently, many assessees use their portfolios to undertake a weak form of reflective practice that puts the focus on what happened and how well it met the requirements of the situation.

The portfolio of a mental health branch student supplies the following example of a critical incident in practice and the assessee's subsequent reflection upon this. The assessee had been working with a staff nurse, 'specialling' a young girl who persistently self-harmed: their remit from the nursing care plan was to provide distraction to divert the girl's attention from self-injurious thoughts and behaviour:

> *'We were sat at the dining table and I couldn't get S interested in food at all. She refused point blank to eat. Then I was able to find a copy of B [fashion magazine] and she looked at the pictures of clothes with me for quite a while without expressing any thoughts of self-harm. I felt this was a successful use of distraction which we had been instructed to do.'*
>
> (Pre-registration assessee, Mental health branch)

The portfolio was used to provide evidence of ability to practice effectively and to suggest the assessee knew how to put right what they did not get right the first time.

Learners are anxious indeed to demonstrate what they can do in the practice context:, but are aware that they often do not do so because they are insufficiently knowledgeable.

> *'I do know basic things but that's not enough. I know to go to others and say "there's something wrong" … But I should be able to do more than that. I feel I should be able to formulate … to think "right, that happened, what I need to do now is a, b and c" and I may need someone to watch me do that but I should be able to work out what plan I need to remedy what's happening … in some situations I can but in a lot of them I can't. The thought of wearing a blue dress and people, as soon as they see you saying "oh, she's a nurse, she knows what she's doing". And I feel I'm going to be putting people at risk once I qualify.'* (Third-year diploma student)

Many, like the student quoted, know their limitations and will ask for assistance because they are concerned about the implications for practice and patients. Others will try to impression-manage, preferring that their assessor thinks they are getting it right:

> **Student 1:** *'We have tutors but we very rarely see them … think I have seen one during the whole of the course since I've been here.'*
>
> **Student 2:** *'They just don't come round … I'm not the only one, I don't think.'*
>
> **Interviewer:** *'So very few visits from link tutors, but if they do come … if you have had a visit, what happened?'*
>
> **S1:** *'I got asked just "are you alright?" and "do you know how to contact me?"'*
>
> **S2:** *'I got the same … exactly the same.'*
>
> **I:** *'What would you like to have done when they came?'*
>
> **S1:** *'It would have been nice to go off, have a drink and sit down in a quiet place and talk to them about what we were doing in the placement area.'*
>
> **I:** *'… You're told to ask questions and challenge and criticise … could people say "well, there are a few things I've been wanting to discuss with the ward sister, perhaps we could discuss it now?"'*

S2: *'Well, no, because you're being assessed by them … so you'll end up with an assessment that is really not acceptable.'*

(Interview with third-year pre-registration diploma students)

It seems unlikely that assessees in this latter group (and learners move in and out of this group according to circumstance and their relationship with colleagues) will not also use their portfolio to show they are 'doing it right'; after all, it carries a substantial proportion of coursework marks. The problem is, directions on the purpose of the portfolio of evidence are ambiguous and, in the event, assessees collect evidence to prove their competence rather than as the focus for dialogue with themselves and others.

Educator-assessors, on the other hand, while acknowledging that assessees are often confused about the purpose of the portfolio, hope for something more reflective and analytical.

*'There's a lot of confusion from both lecturers and students as to what goes in [the portfolio of evidence] but what … the idea being that we're encouraging them to explore what they want to learn, what their strengths and weaknesses are and to see that they evolve over the three years … and whether it will work or not we'll have to wait three years to find out.'*

(Programme co-ordinator, Pre-registration diploma programme)

But, as the above comment shows, even in talking about reflection, they are placing a focus on exploring strengths and weaknesses. If not clarified, strengths and weaknesses can be equated with getting it right. And because they are not explicitly directed to analyse the extent to which *situational features* affect the *scope of possible action*, few assessees write about their actions in terms of the negotiation with the situation they had to do to practise in the way they did, or the choices they made and the constraints which affected their decisions. Where choice and judgement are at issue in an action they are mostly written about with a focus on outcomes and resolutions, rather than the processes by which problems were addressed.

*'I had to admit two new patients that I am "named nurse" for. One was an Indian lady and it was difficult filling in the admission form and doing her care plan. Luckily she had been in before so I did not have to find out all that much detail. The other was for a lady for a repair and that was much more straight-forward. I completed all the form and started her care plan.'* (Pre-registration student, Adult branch)

Where used to record and reflect on what has happened, portfolios are liable to become mechanisms for *closure*. They provide accounts of what was done, the knowledge drawn on to inform the doing, and an informal evaluation of how far the writer got it right. In this mode they perform a useful function, enabling the writer to demonstrate awareness of the information-action relationship and providing a foundation of evidence from which they can move from particular events to construct a bigger picture. Used as a location for recording reflective, narrative accounts of what was done, portfolios provide a database of evidence for building a repertoire of cases and as such are a valuable first stage in the development of practical competence for the world of health care as it is. Where portfolio entries focus on *completed* thinking and *finished* action, however, the *status quo* is portrayed as normal and consequently preparation for future practice is inhibited. Because the portfolio is constructed after the event, outside the context of action and beyond the context of initial understanding, it tends to focus on completed action and away from issues of agency.

### 7.1.2 The portfolio as a place to display knowledge

Because portfolio assessment is almost exclusively undertaken by educator/assessors, writing is almost always assessed for its academic quality. Assessees often perceive this to be a priority and are cynical about the process:



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*'My tutors … aren't observing me doing anything … they assess my [portfolio] … they're assessing your academic skills really, aren't they? How you apply your knowledge to your practical area … that's what I interpret it as. Whereas the [diploma] students that come to my ward, you're not just assessing their academic skills, you are assessing their physical skills in the way they perform their job, how they relate to people as patients, and how they relate to all the staff as well and all the disciplines, which is something we are not assessed on, doing an academic course.'*

(Post-registration degree student, practitioner-assessor and ward manager)

However, what is judged to constitute academic quality in writing about practice, varies considerably. In academic writing *per se*, these qualities include explicitness, logic, persuasively organised argument, balance of argument and evidence and decentring of the author. Most common among the things looked for in the portfolio by nursing and midwifery educators, however, are:

- evidence that the assessee is aware of relevant knowledge
- evidence that the assessee can see how knowledge might be applied in practice
- evidence that the assessee can give a conceptually coherent account of their practice
- evidence that the assessee can demonstrate understanding.

The writer's task is to display knowledge, with knowledge – and by association practice – implicitly defined as that which matches up to and/or persuades established thinkers (and practitioners and practitioner-thinkers).

*'Portfolios are often used by students to capture - encapsulate what for them is a novel concept, often by including quotations from lectures or inserting copies of tests they have done. Some, especially in the early stages of the course, copy paragraphs or diagrams from text books to illustrate a particular knowledge point, but these are often isolated clusters of text giving no individual interpretation or even an indication that the student has understood the material involved, and providing little, if any, evidence of analysis, reflection or application to practice.'*

(Researcher's field-notes 4)

*'CFP assessee's portfolio entry compiled during an elderly care placement. In this section, she attaches two laminated print-outs of well-known pressure area risk assessment scales, provided as hand-outs by pharmaceutical representatives supplying medication to promote tissue viability. Her written comment in support of this "evidence" reads: "Pressure area care is important on care of the elderly wards. There are two scales for measuring the risk of pressure sores on wards D and E, where I have worked. They are the Norton and the Waterlow scales".'*

(Researcher's field-notes 5)

*'A portfolio entry which was commended by the student's tutor included an account of her care for a little boy who had required hospitalisation for bronchiolitis, but who also was diagnosed as autistic. The child's care was based on a model of nursing (as used on the paediatric unit) which was, in the judgement of the tutor, "correctly referenced and applied", although the student had made no attempt to "unpack" this concept further, merely following the routine care plan exemplar provided by the ward. She had, however, described her unfamiliarity with the pattern of behavioural difficulties exhibited by the little boy as his physical condition improved, and the measures she had adopted to try to gain the child's trust before*

*instigating any necessary nursing procedures. Most significantly for her tutor, she had been sufficiently interested to read quite widely around the topic of childhood autism, refer to this, and include the relevant information sheets she had acquired from a national charity.'*

(Researcher's field-notes 6)

Most educator/assessors, then, treat the portfolio as a locus for displaying knowledge and thinking, where assessees can demonstrate their level of thinking in relation to their practice experience (Cox et al., 1991). And many treat evidence of ability to do all the things described as a high *level* of competence in practice, and ability to do only some of them as a lower level of competence.

To demonstrate these things in their portfolios, most assessees present a highly selective, ordered, organised, tidied-up version of the world of work, portraying the practice environment as a world they have *mastered* by thinking about it. This they do because they think their assessors want them to demonstrate *mastery*.

*'It's more we have to write about it … I mean, you can lie, saying that you do it … which I'm sure I do … You say you do this, this and this and when you actually come to do the [work], how much do you stick to that? … Because you come up against restraints, resources, hiccups.'*

(Post-registration degree student)

The problem with all these constructions of the portfolio as a device for assessment is that they prioritise end states (achievements) over the continuous negotiations (uncertainties) that characterise actual practice. In fulfilling its role as repository of evidence of successful, informed practice and indicator of levels of thinking, the portfolio becomes a *post hoc*, other-oriented, non-practical device. It can and does serve a useful purpose as a mechanism for ensuring that assessment is evidence-based, but in doing so it makes uncertainty, diversity, ambiguity and complexity (all aspects of practice itself) aberrant.

### 7.1.3 The portfolio as a place to *'write a good practice'*

As a device for assessing competent practice the portfolio suffers from being a textual representation; it is not, and cannot be, the practice itself. Assessors, particularly educator/assessors, can become concerned more about writing competence than competence to practice. Most practice-assessors look for ability to do and apply knowledge rather than presem it academically:

*'Students will learn practical skills in the clinical areas … they might be able to 'ell you the theory of asepsis, but in practice they don't have it … the balance has gone too far towards the theory.'* (Practitioner-assessor)

Many educator-assessors look for ability to write about experience in an academic way and their perception of the writer's competence is affected by their ability to do so:

*'Obviously if someone comes in with the skills of evaluation and synthesis they'd be getting marks that were equivalent to a first or a 2:1 … but its much easier for an student who can describe and demonstrate the lower cognitive-level skills to get a good mark in the first year … but in the second year we would have expected them to be up a notch so therefore the criteria and the way we actually mark them we're looking for different things … that's the theory anyway.'*

(Curriculum co-ordinator, Post-registration degree programme)

Some, as the extract below reveals, see the task as more complex but still recognise that many of their colleagues expect the writing to demonstrate academic qualities, such as analysis, and to be presented in a particular form:

> *'A further area of apprehension, which is raised by the assessors, concerns the inconsistency they perceive to be evidenced across the School in the major exercise which is an attempt to apply continuous assessment to an activity which unites theory with practice – the student portfolio. The stated aim of this on-going exercise is for the student to provide a record of their 'progress' in terms of 'clinical experience, research, reading and reflection on practice.' ... The difficulty for the assessors is twofold: how to advise the students as to what to include and how to present this.* ***They are aware that the students' portfolios are marked internally by their individual academic supervisors throughout the course.*** *They are also aware that there appears to be a level of inconsistency in this marking, with some students being required to present outline evidence of salient observations, clinical experience, skill acquisition and associated reflection, while others are required to produce 'masses of materials'. The lecturer confirms their perceptions: some academic supervisors are perceived as 'lenient' and justify their position in terms of the relative novelty of the exercise, even for experienced nurses,* ***while others demand not only a more selective inclusion of material but also that the student gives a rationale for this and is able to provide a greater level of analysis.'***
>
> (Researcher's field-notes 7; emphasis added later)

Certainly, many educator-assessors recognise there is a gap between a good piece of writing about practice and the practice itself:

> *'But of course I am ... its only just recently that we have actually introduced those and again I feel that sometimes students ... how I see it ... are progressing well and obviously they are doing well in practical areas because they are getting a lot of favourable comments from the [practitioner] assessors ... you know, to me and to the student ; and yet how they actually write their reflective diary doesn't necessarily demonstrate their progress.'* (Co-ordinator, Pre-registration diploma, Child branch)

One consequence of the focus on academic qualities is that people who have spent least time in formal education find portfolio writing most difficult. They are doubly handicapped by the fact that they have not previously learned the rules of the genre and do not feel confident as writers in any academic genre. From interview comments it is apparent that unless portfolio writing encompasses a wider range of types of writing than is common at present, less accomplished writers will be disadvantaged by not being able to 'write a good practice' – to construct an account that conforms to the style of portfolio genre writing and so presents the writer's practice experience and knowledge in ways that display them in relation to academic criteria.

Despite the value implicitly attributed to the style and quality of writing, portfolios are often assessed in ways that suggest the text is transparent, that it is meant to be 'looked through' to where the practice can be seen. Most assessors examine a portfolio to see what it says about the writer's clinical practice. What is forgotten is that the portfolio is itself a practice of which the assessor can ask, 'what is this practice (this particular portfolio) evidence of?'

The portfolio is not a practice in the sense of being located in the world of action. But neither is it a non-practice. It is a practice in the sense that all texts are practices, a place where the writer (and later the reader) 'does things' with personal, professional, economic and ethical discourses. As a practice it is the site of continuing interplay between different values and understandings. This means it offers evidence of the writer's ongoing engagement with uncertainty and their degree of comfort in working with diversity and complexity.

There are two implication here. First, the best place to see and assess practice is in practice itself. Second, the portfolio's most useful function is as a practice rather than a text.

### 7.1.4 The portfolio as a place to develop practice through reflection

The shortcomings of the portfolio as a device for assessment would, to a certain extent, be ameliorated if we could be certain that reflection in writing transferred to practice and made a direct impact on competence (Chinn and Kramer, 1993; Johns, 1995). This research has examined, through observation in clinical environments, the relationship between practice, reflection and assessment. It has identified one major problem of the portfolio to be the fact that it is employed as a 'bolt-on', after-the-event assessment activity which unwittingly divorces assessment from the doing of care. Reflection that occurs in writing the portfolio need not necessarily transfer to the practice environment.

The research team has observed that what is assessed, how it is assessed and the way variations in criteria and practice are dealt with, affect the quality of reflective practice in general. The positive side of this is that the very existence of the portfolio as an assessment tool can motivate a change in attitude to thinking about the medium and longer term.

What was not established beyond doubt was that this change in attitude transferred to practice in the short term. This is not to say that it did not, but that at present there is no actual evidence of this. Absolute claims that portfolio assessment is valid for evaluating how a person is likely to be in practice are suspect. Further research is needed to explore this.

### 7.1.5 Strengths and weaknesses of current portfolio use: a summary

Portfolios are most often constructed as collections of evidence of practice that can be considered (or reflected on) by more than one person. The creation of a databank of sharable evidence from a range of sources was advocated by Bedford et al. (1994). Portfolios are often used as a focus for dialogue, as also advocated. However, because assessment is perceived by many as primarily a regulatory activity to control access and promotion within the professions, the summative function of portfolios has come to assume greater significance than their formative function. Both assessors and assessees treat the portfolio as a place to display knowledge and achievement and show that they practised successfully. Indeed, in this capacity it is a valuable assessment instrument because it provides evidence of the writer's repertoire of practices for 'doing care' and promotes a concern for evidence-based practice and assessment. Unfortunately, it is also a problem because it emphasises achievement, with its implications of closure, and moves attention away from situated action, knowledge and decision-making. Although this is sometimes ameliorated by the concept of levels, seen as continuing development, movement through levels is often narrowly conceived as increasing *conceptual coherence*, which is not necessarily a good indicator of competence in practice.

## 7.2 Less common uses of the portfolio

Although assessment criteria often state that portfolios should include critical analysis, evidence suggests a limited interpretation of critique.

> *'Select an aspect of practice and reflect on what you did. It is probably helpful to think of a situation which you felt went particularly well, or one which could have been better.*
>
> - *What did you do?*
> - *What did you want to achieve?*
> - *Why did you do what you did?*
> - *What were the results – for you, your colleagues, your patient(s)?*
> - *What did you feel about this?*
>
> *To analyse your practice you should consider the following:*
>
> - *What did I do?*

- *Why did I do it that way?*
- *What was the result?*
- *Could I have done it any differently? Would it have been better? Would it have been worse?*
- *What have I learned?*
- *Would I do it the same way again?'* (Portfolio instructions)

Only where they are explicitly directed to look beyond what they did in the situation at the time do students begin to explore alternatives to what they did and alternative contexts for doing it. When this happens, the portfolio becomes a place where the writer can consider alternative practices and contexts, identify differences in approach, explore the discourses that motivate them, and prepare for practice in the ambiguous and uncertain world of the future. Observation of practice suggests this should be one of the main functions of educative assessment.

### 7.2.1 The portfolio as a place for imagination and dissent

Practitioners' sense of agency (their power to achieve) and disposition to open-mindedness are professionally and organisationally constructed. They become *initiators* or *responders* in the course of their work, negotiating the extent of their agency through interaction with organisational structures that are themselves part of a continuous process of negotiation between forces of innovation and conservation. In moving to a position of greater or lesser agency they draw on a view of where they are going, what it means to be them and what it means to be a professional in that particular culture. In writing a portfolio they either reiterate or challenge those positions.

If practitioners are to be effective carers in a constantly changing health service whose future profile can only be guessed at, they must be capable of envisaging alternatives to 'now'. This requires them to be confident as well as competent, disposed to taking initiatives in unusual as much as routine contexts and able to exercise judgement. They need to be both doxosophes (holders and expounders of legitimate knowledge and practice) and dissenters (constructors of heretical alternatives) and to be able to contribute to the critical mass prepared to challenge the orthodoxy and hegemony of 'consecrated experts' who have the power and desire to keep things as they are. This will require them to engage in heretical discourses that challenge the *status quo* and open up the possibility of difference in the future; when prior experience leads people to believe that they can do nothing to change their lives, they stop trying to improve (Peterson et al., 1993). To be educationally useful, portfolios must promote imaginative leaps forward to a virtual but inevitably different longer-term future. And, if they are to have *assessment* validity they must focus on the quality of the writer's imagining.

### 7.2.2 The portfolio as a place to prepare for practice in a context of ambiguity and uncertainty

Most portfolios do not tell us how well prepared the assessee is for practice in an unknown and constantly-changing future. To assess that, they must encourage and be assessed for the writer's ability to be prospective, to *'look into the distance'* (from *prospicere*).

Prospective practice is significantly different from reflective practice as currently interpreted and assessed by most nursing/midwifery educator-assessors, practitioner-assessors and assessees. Currently, most assessment treats reflection as a process of looking at what has happened and looks for explanation and justification of it. Prospective practice moves away from the production of analogues of the past, constructed around (imperfect) memories, towards envisioning futures. Practitioners who are to contribute to change for the future need to demonstrate the imagination to tolerate ambiguity and appreciate complexity. They need to understand the duality-within-singleness of (a) 'action-now' and (b) 'possible-action-in-an-imagined future'. Practice assessment must track the development of this understanding.

A valid portfolio assessment of these things would examine the writing for evidence of what it revealed about:

- the writer's disposition towards 'agency'
- the writer's capacity to act in contexts of uncertainty
- the writer's understanding of diversity, ambiguity and complexity
- the writer's capacity to imagine alternatives.

It would also assess the writer's dispositions, attitudes and understandings in relation to detailed accounts of particular instances from the writer's own experience.

Portfolios are designed to capture post-event *thinking* at a distance from the *context of action*, reveal the thinking that takes place in the workplace, and how it has contributed to the negotiation of action there. The extent and quality of a person's capacity to *act* in the light of their thinking can only be examined with an appropriate form of practice-based assessment that captures the assessee's competence as doxosophe, dissenter and *actor*. This requires assessment of practice through observation in the practice environment as a complement to the portfolio (Chapter 8). But projecting forward from observation in clinical environments for this research, we would suggest that it is likely that if the assessment of practitioners' fitness to practice in the 21st century is to continue to include a portfolio element, assessment criteria will need to identify six capacities that receive relatively little emphasis in most current portfolio-based assessment schemes as they are actually practised, even if some appear in guidelines on how to write the portfolio.

Portfolio assessment, it seems to us, must capture an assessee's ability to:

1. ***critically analyse*** the way things are currently done
2. identify the ***values*** inherent in current practice
3. critically appraise ***the context(s)*** of current practice
4. imagine ***alternative contexts***
5. imagine ***alternative ways*** of 'doing'/promoting core values
6. envisage ***strategies*** for change.

## 7.3 Complementing the portfolio

Valid assessment of competence to practise must begin where the action is, in the practice environment, where it is possible to focus on the complex and dynamic activity that constitutes nursing or midwifery. It must work within the culture and capture the reality of situated practice, capturing evidence of situated negotiation in action and situated decision-making, through which access to practical understanding is demonstrated.

The portfolio allows access to *theoretical* understanding and, potentially, to intellectual capacity to analyse values and contexts, imagine alternatives and envisage strategies for change. These are essential competencies for an autonomous professional; however they are necessary but not sufficient qualities. Practitioners also need to be able to envision alternatives and strategies and to enact them in the clinical situation. This requires situated understanding and the ability to 'do' nursing/midwifery. To access *practical* and *situated* understanding it is necessary to see assessees in the practice situation negotiating their actions with patients, colleagues and the environment itself. To be valid, assessment must *identify* these things; to be more than a bolt-on activity it must be part of the process of *facilitating* them. This requires a step beyond portfolio assessment, which serves a valuable but different purpose.

### 7.3.1 Practice-located, spontaneously-occurring alternatives to the portfolio

This research has identified several more or less spontaneous, informal forms of assessment that allow a degree of access to practical understanding.

#### 7.3.1.1 Informal, situated conversations

When assessors work alongside assessees as they get involved in situated negotiation of their practice, informal, on-the-job conversation happens. In these conversations, ideas and understanding are performed (rather than made explicit) through a democratic process of exchange in which equal value is placed on what each individual brings.

> *'An assessor and her student are working together, making a heavily sedated, terminally ill patient as comfortable as possible. As they work, the assessor and student discuss how best to position the patient. The student is clearly able to see areas of tissue damage which the assessor cannot from her present viewpoint. They modify the planned position accordingly, equal value being placed upon the student's observations from her 'unique' viewpoint.'*
>
> (Researcher's field-notes 8)

#### 7.3.1.2 Problem-solving out loud

Less common, but nevertheless relatively frequent, are the problem-solving discussions that happen during moments of crisis. They are event-focused and directed towards practical action; they reveal practical understanding (which is, of course, theorised). They always involve two or more people and therefore make private understanding public, although usually without framing that understanding as explanation. They commonly involve practice that is taking place in clinical environments where there is pressure to construct new knowledge, as for instance, where professionals from different professions are working closely together.

In the example above, the assessor and student agree to modify their planned position for this patient as a result of the student's information. The assessor instigates this change of plan, totally relying upon the student's 'expert view'. She does this by 'thinking aloud', involving her student with the following remark:

> *'Oh well, if you can see that and that's actually happening now, we really can't put her over on her side – well, not completely. If I take her through a bit more this way – I'll not come round to see. It means disturbing her more. So what if we just gently lift her through to me? What if I work your side next time we move her? That way I can get a look at it myself without disturbing her too much. Perhaps we can work out a better way to go.'*
>
> (Researcher's field-notes 9)

In this example, the assessor is modelling problem-solving through talking out loud.

#### 7.3.1.3 Telling tales

One way practical understanding gets talked about is through stories. These enable understanding through the sharing of cases from each person's experiential repertoire, permit the imaginative exploration of alternatives and enable the particular and the universal to emerge together. They enable understanding through sharing at a pre-conceptual level but also capture intuitions and make them accessible to scrutiny. In addition, they enable the future to be imagined. Stories do not always occur in well-formed narratives but often include gossipy chat at (for example) lunchtime and coffee breaks.

The following examples from experienced professionals would be useful starting points for the exchange of stories between assessor/assessee, and for the exploration of values, dilemmas and choices.

*'We had a patient I had three attempts at – to get a vein – you know – I reckon I could get blood out of a stone! And the chemo nurse had three attempts, the same as me, very experienced. Then the haematology registrar, he had three attempts. By this time the patient had nine holes in his arm – and we got an anaesthetist, and they are the experts – and he got a vein on the third attempt.*

*It was a very difficult scenario. The last resort was the anaesthetist … and he had problems. The patient coped very well. We all had to.'*
(Clinical nurse specialist, Haematology)

*'Of course, community nursing's changed an awful lot in the years I've been in it. There was a time when you would have gone to one of these little houses miles out. No mains or anything. You know – they'd have a closet – an earth closet, in the garden. In some of these way out little villages it went on for a long time, until quite recently really.*

*And I remember taking the seat out of a kitchen chair and putting the bucket under for someone to have an enema. What we'd have given for micros then! I expect that will all change too … get even smaller or just so easy to give that all the patients just do it themselves.'* (District nursing sister)

### 7.3.2 Constructs that might complement the portfolio

It has been argued (in Chapter 6) that the work of nursing and midwifery is theorised in the doing; it is developed out of the unavoidable daily attempt to deal with the pragmatic and the political. The practices of clinical workplace assessment are a response to:

- the demands of the workplace
- the demands of professional higher education
- the demands of government
- the need to reconcile competing discourses
- the need to reconcile contending practices.

It has also been argued that the assessment of practice must look at practice as 'survival' *(what can be made to work)* and give due attention to the assessee's *pragmatic theory* framed in response to insufficient resources and unacceptable workloads and constructed around answers to the questions:

- How can I find the time/space to do assessment without prejudicing patient care?
- How 'do-able' is the assessment?
- What am I looking for?
- What do I have to do to show I have carried out the assessment task?

It has been suggested, too, that practice assessment must examine competence as preparation for progress *(what might be caused to happen)*, considering carefully the assessee's *developmental theory* framed around answers to the questions:

- How can we contribute to the improvement of practice?
- How can we promote the development of safety through understanding?
- How can we encourage assessees to formulate theories about their practice?
- How can we encourage assessees to draw on research evidence to inform their practice?

Finally, it has been argued that practice assessment must examine assessees' preparation for a different future, for which they will have to construct a preferred version of the future

(what we would like to happen) examining their *hybrid* (pragmatic/developmental) *theory* built around the questions:

- How can we systematically monitor standards?
- How can we reassure the public (voters) about safety?
- What can we reasonably guarantee?

Despite the research team's arguments setting out these theories of practice and practice assessment, it is acknowledged that theories of practice assessment resist the constraints of the 'master theory builder'. The theory which practitioners develop as they 'do' caring and assessment, is more powerful than that of the detached academic, who is easily misled into believing their privileged standpoint enables them to see the 'truth'. The teaching task is not to find the right theory and make it available to the people who have to do the work it is expounding, nor is it the task of assessment to test the fit of practitioners' theories to an ideal theory. The task for the assessor is to find out what theory/theories practitioners are working with and to evaluate the effectiveness of those theories in enabling them to provide quality care within the realities of the clinical workplace.

Because an assessee's theory of practice emanates from active engagement with contending discourses and competing practices and is situated, practical and dilemma-driven, assessment must be similarly engaged if it is to capture an assessee's practice/theorising *in situ*. However, because situated practice assessment – like practice itself – is affected by insufficient resources and unacceptable workloads which help to make it *ad hoc*, intermittent and unsystematic, it is sensible to look for situated versions of the portfolio that reduce the impact of the workplace curriculum. Some of these situated alternatives are likely to be spoken texts/practices rather than written ones, a few may be both written and spoken.

Speculating on isolated examples from observations in the workplace, we suggest below two possible ways of complementing the portfolio with constructed assessment devices.

### 7.3.2.1 The vignette as a new form of construct to complement the portfolio

There is a case to be made for presenting *narrative* accounts of practice for assessment. These can be imaginary, composite accounts:

> *'We had a very nebulous and academic sort of community study before where they were just told "go out" but we find that relating it to a specific and saying "OK, this is a family and they all have their problems" and "how could we help them?" … I think they sort of attached … and I had some very positive feedback from it, and "we like the Thompsons" was the general comment.'* (Lecturer, Pre- and post-registration diploma programmes)

They can be condensed case studies:

> *'You have to create the situations in which they then use some sort of analysis … sometimes you can use clinical experience and certainly we are hoping to do that later on for community assessment with the new course where we ask them to look at case studies.'* (Lecturer, Pre-registration diploma programmes)

They can also be based on fully-researched *'thick description'* (Denzin, 1989) of the situation the assessee is actually in, through which the writer can represent his or her dispositions, attitudes and understandings as contextualised, embedded elements of practice, as for example, in the extract below where first the general context and then the more immediate situation are described. Included in the narrative is an account of the writer's feelings:

*'The care team in this hospice comprises individuals from a variety of professional disciplines; nurses, teachers, Montessori teachers and nursery nurses, play therapists, social workers and physiotherapists, supported by care assistants, cooks and domestic staff. There is consultant paediatric and general practitioner medical input when required. The care for each child is given on a one-to-one basis, so a multi-skilled approach is used and all the staff learn a complementary range of skills under the professional direction of their appropriate colleagues. Staff members are paired to provide continuity of care for the child and for mutual support.*

*I have been on duty today working alongside my clinical assessor providing care and support for child M and his family. This eight-year-old boy has a multiple pathology with a life-limiting metabolic disorder, congenital abnormalities affecting respiration, speech and mobility and a severe skin condition. He has a permanent tracheostomy and requires tube-feeding. His care is provided at home by his family with community paediatric nursing support from the hospice and intermittent admissions for respite. His two sisters are not at school (this being their half-term holiday) and are staying here with their mother in the family room for the first few days of this admission.*

*The boy's mother seemed content to provide the physical care needed by her sick child, using the nursing staff as confidantes and to confirm that her own management of the tracheostomy had been satisfactory. She was happy to let my assessor take over the morning chest physiotherapy while she went into the village to take the girls and herself for a hair appointment. My assessor did the tracheostomy herself while I observed. Together we prepared the boy's feed and then I administered it. After lunch when the family returned, the boy's mother stayed with M while I found out from the girls what they would like to do. They opted to spend the afternoon on the nearby beach and all four of us set off accordingly, returning to the hospice for tea at 5.00.*

*The eight-hour shift ended at 6.00 and my assessor used part of the last hour to discuss the day's activities and any concerns. I told her I found it difficult to see how the family was getting respite when the mother remained in the hospice with her child giving all the care throughout her stay. It seemed to me the staff were being lazy. I did not tell her this, but I was also concerned that I was not getting the opportunity to practise the nursing care required.'* (Student portfolio entry)

Vignettes/case studies are open for public discussion about the relationship between practice, context, dispositions, attitudes and understandings. Assessment would involve consideration of the extent, range and effectiveness of assessees' actions in the light of their judgements, the knowledge and values that underpinned these, and the contextual constraints with which they were obliged to negotiate. (Vignettes are discussed in greater detail in Chapter 9).

#### 7.3.2.2 The clinical team meeting as a pre-existing structure to complement the portfolio

This project has identified the reality of team assessment, and has found strengths in this approach (particularly its focus on the oral and observational rather than the written) but has also identified significant shortcomings. The chief shortcoming is the fact that assessment criteria often differ from one team member to another and are rarely discussed. This, however, means that teams are inherently sites of dialogic potential; they are able to start with a notion of



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common purpose while acknowledging difference. Without difference, there cannot be dialogue. However, there will always be heterogeneity of values, experience, expectation, knowledge and confidence in any group, and dialogue is inevitable where teams are working. Every action within the context of the team is a contribution to the dialogue. Where assessees are fully-integrated members of the team their contribution to the dialogue is available for practice-integral assessment. To enable them to work together a clinical team has dialogically to explore differences.

> *'We work in teams on the ward where I work … a student would be allocated to an assessor at the time when they come to the ward and they would be allocated to a team with their assessor being in that team … but if that person isn't there all the time [the students] know that they are allocated to a team of other people who may well be assessors for other students, so they're not left to their own devices. They would work alongside that team of nurses so then generally the whole team can give an indication as to how they feel the students are getting on … they talk together, work together in the team.'* (Ward manager, Orthopaedic trauma ward)

To enable them to assess practice validly and reliably the team needs to replicate that working process. In practice and assessment it is necessary to act, review and adjust through action. The aim is not to become the same, to all act in the same way, but simply to reach a common understanding. It is not always necessary or appropriate to strive for explicit principles (although this is not excluded) because the dialogue results in a *'sensus communis'* or community sense (Vico, 1774; 1992).

It follows that teams are well placed to carry out assessment. In their daily activity and dialogue they will already have taken account of the complexity of practice environments and have attributed value to pragmatic theory and practical decision-making. They will already have incorporated into their working together the regular review of priorities. Their practices will include dialogue in the light of conflicting demands, disagreements and differences of opinion, and their focal point will already be points of choice and moments of decision-making.

> *'I mean a typical day, if you want the run-down of the day, we would have reporting teams in the morning then the student along with her team would go on to their team and start getting on with the duties for the day. Any changes that are given regarding patient care I would then inform them as a team of the relative changes to the care that is being given, or the treatment, and they would work alongside the team members …'*
> (Ward manager, Orthopaedic trauma ward)

Where members of a team take a step beyond team practice to team assessment, they are already experienced in critical analysis of disagreements. They are ideally placed to ensure that assessment is part of a continuous process of evidence collection, analysis, reflection and action, where the dialogic exploration of differences is a key element.

## 7.4 Conclusion

This research establishes that the portfolio is potentially an excellent *educational* device for facilitating thinking and reflection, although the quality of these could be improved with the introduction of clearer criteria for evidence collection, analysis and critique. It shows that where criteria are clear, the portfolio is a valid assessment tool for assessing the range of intellectual activities referred to. It also reveals, however, that the portfolio does not provide valid evidence of practical understanding or of competence in negotiating within a context of action. For these, additional forms of assessment are necessary. In the meantime, portfolio-based assessment can be further developed to examine the portfolio as a practice in itself which reveals ability to reflect on alternative courses of action, imagine different practice scenarios, reveal the values behind practices, appraise contexts and rehearse strategies for the new.

## 8.1 Introduction

The value of the practice curriculum as a course of reflection upon experience that informs judgement for professional development and action depends upon the quality of evidence produced by student and qualified staff. Chapter 7 discussed the reasons to move beyond the current portfolio approach; this chapter explores issues in relation to designing curricular and assessment strategies, focusing upon the processes of practical reasoning sketched in Chapter 2.

Although both the nursing and midwifery professions specify in broad terms what a practitioner must be able to do to be registered (baseline competence), in practice the professions take many forms. In effect, practitioners 'do' nursing or midwifery as a number of types of practice involving thinking, doing, feeling and being. Each form, however, requires both theoretical knowledge with professional understanding and practical know-how with technical skill. This is what is meant by practical reasoning. Practical reasoning takes place within or across a range of domains: intellectual, practical, management, educational. Thus, when students move up a level in their practice they do so within a *domain of practice* or an *intellectual domain* in a way that makes them as fit for purpose as it is reasonable to expect in the light of resources available. Within the domain of practice levels of practice are evaluated in relation to development within a *field* of practice, either as a specialist with advanced technical skills, or as a generic hands-on carer. Within the intellectual domain they are evaluated in terms of ability to rationalise action, see principles, undertake critique and conceptualise alternatives. Alongside this is a *domain of management* and a *domain of education*. The research data suggest that it is misleading to see levels of practice as related to movement from one domain to another; movement within these domains are happening in parallel (Chapter 6). This chapter focuses on the practice and intellectual domains as the ground for assessment and curricula design.

## 8.2 The practical domain ('being' and 'doing')

Most practitioners complain that insufficient opportunity for career advancement is offered to those who want to become advanced practitioners within the hands-on care domain. Although a practitioner with newly-acquired knowledge or newly-perfected clinical skills is more advanced than they were before, they are rarely appointed to a senior grade just because they have added to their knowledge and techniques. They are often unable to get such an appointment even when their experience suggests they can use their knowledge and skills across a good range of field-related contexts.

The data reveal that many practitioners believe a basic error has been made by the nursing and midwifery professions in accepting a wage structure that associates higher grades with specialised skills. The point is articulated here by a post-registration student:

> *'I'm not sure that hands-on nursing care excellently delivered is really valued and I think it's reflected in the political drive towards the creation of all these nurse specialists, which is saying that some aspects of nursing require this nurse specialist with this big badge with nurse specialist label on it … does certain things really well. And I think part of it is the underpinning politics of what is going on in nursing today that actually removes the value of what nursing is and what nursing does. That sounds terribly trite but I think it's something about valuing the art of nursing as opposed to acclaim that's given to somebody with a degree … because those sort of people, on the whole, don't seem to stay in practice, do they?'*
>
> (Post-registration student)

This nurse sees the fragmentation which has accompanied specialisation, as a betrayal and a devaluing of the main currency, *'what nursing is and what nursing does'*. Furthermore, in her view, the betrayal is to equate specialisation with degree-level work and place general nursing below it. The equating of levels of award with academic ability clearly rankles. The interviewee is arguing for a form of assessment which gives value at advanced levels to what might be termed traditional nursing practice. For her, this is a key principle by which professionals may *strategically* organise their understanding of and explanations of practice circumstances. The methods that are *tactically* employed in order to achieve this principle do not necessarily differ radically from the methods employed to articulate the principles they oppose. Consider the following:

> *'A 65-year-old builder is admitted to A&E with severe lower back pain, after falling from a roof. The student (adult branch) works with his assessor to move the patient and position him for examination by the orthopaedic registrar; his first experience of the 'log-rolling' technique, performed under the explicit instructions of the assessor. Following this, he feels sufficiently confident to accompany the patient to X-ray where he now takes the lead role, transferring the patient from trolley to X-ray table and back. They return to A&E where a diagnosis of fractured lumbar vertebrae is confirmed. The student completes the nursing record, assessing the patient for risk of tissue damage and performing and charting baseline and neurological observations. The patient is to be admitted to the orthopaedic ward, having a CT scan en route. The student again accompanies him, providing sensitive care and directing the 'log-rolling' procedure required for each transfer. After giving ward staff a verbal handover, he returns to A&E, updates his assessor and completes the departmental records. This entire episode has lasted 31/2 hours during which the student has been able to rely upon his assessor's support and guidance regarding learning opportunities presented.'* (Vignette 4)

This brief narrative can be analysed as follows:

**Circumstances**

**Place:**

- A&E
- X-ray
- Orthopaedic ward
- CT scan.

**Resources:**

- Appropriate staff
- Time
- Equipment: X-ray, CT scanner, trolley, bed etc.

***Dramatis personae*:**

- 65-year-old builder
- student
- assessor
- orthopaedic registrar
- ward staff.

**Orienting categories:**

- lower back pain
- fractured lumbar vertibrae.

**Strategic level**

- Care principle: – traditional nursing practice? Provision of sensitive care
- Education principle: implicitly – see one, do one? Instructional teaching.

**Tactical level events/procedures/outcomes**

Scene 1: A&E

- position patient for orthopaedic registrar
- employ log rolling procedure
- show log rolling procedure; give explicit instructions
- outcome:
  - performs procedure
  - increased confidence.

Scene 2: X-ray department

- student takes lead
- transfer patient from trolley to and from X-ray table.

Scene 3: A&E

- confirmation of diagnosis
- completion of nursing record.

Scene 4: transfer to orthopaedic ward

- student accompanies
- provides sensitive care
- directs log-rolling procedure
- gives verbal handover.

Scene 5: A&E

- updates assessor
- completes departmental records.

**Overall tactical outcome:**

- care provided
- support and guidance from assessor accomplished.

**Overall strategic outcome:**

- traditional nursing principle reproduced by student.

A lot is left implicit and unknown in such a short vignette. Nevertheless, it does outline a framework for reflection upon key principles and how events relate to these principles. The analytic sketch of scenes and related strategies and tactics shifts attention from the 'doing' to the possible rationales, implicit or explicit, for why particular events take place. Such rationales can then be the object of critical study. Over the three-and-a-half hours covered by this vignette, what learning opportunities have been explored? What is missing from the experience? What



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can be said about the implicit level of learning and achievement? Is such an experience appropriate for a budding professional? In what way is it appropriate and in what way is it lacking?

The questions can be multiplied indefinitely. The student, having experienced these events can reflect upon them. But how? And to what purpose? And to what level? These questions are posed by people who argue for practice-related levels criteria value reflection and knowledge. What they ask is that development is assessed in terms of the quality of nursing as demonstrated by observable patient care outcomes (as traditionally defined). In their scheme of things tangible care outcomes related to real situations and real people would replace context-independent objectives as levels indicators. They would not, however, displace the need for reflection.

> *'We use reflective journals and I don't think … I think we could use assessment use of reflection in a much better way … I think it could be purely a reflective assessment … like I mean it would be a problem because the mentors would need a certain amount of help with it as well but erm, some students go into amazing reflective work, using references, giving examples, being analytical, breaking down what wasn't right, what might improve and enhance practice and I think that's what we might use for assessment as opposed to objectives.*
>
> *In their actual pieces of reflection they're doing all of that and they're just taking it and putting it into these objective things we've got because you know … but I don't think they need to be in the two really, we could really use reflective practice to its real potential – as well as I know its got weaknesses but I think the students could explore them as well in the same process … it's much more of a Level 3 analytical process than I think these objectives are.'* (Community programme tutor)

The process of reflection thus could displace more formal assessment documentation. The problem, of course, in the above tutor's final comment, is that analytical reflection is not exclusively a Level 3 activity; any competent practitioner is analytical when assessing a patient's needs. Immediately an intellectual criteria is applied, the levels category becomes academically rather than practice focused and the student's ability to write becomes an important factor (Chapter 7).

> *'There's a definite progression … there's a definite difference between a descriptive piece of writing and a much more broken-down analytical approach to it and it takes hours.'* (University lecturer: subject specialist)

That movement from description to analysis can, potentially, take away the kind of imaginative leap which characterises more advanced practice. Analysis breaks events down into their parts. By concentrating on parts, the whole is lost. It could be argued that such analysis feeds a tactical and technicist approach to education and care. Outcomes are seen and assessed in isolation from the whole, which is complex and dynamic. What happens in practice can be multiply interpreted according to the particular frameworks of principles and strategic intentions held by a given professional. Any concept of progression is intimately related to such frameworks. Levels are effectively social constructions imposed upon complex learning and caring processes that take place in equally complex practice environments. In moving from context to context, scene to scene the student may look for what is similar or for what is different, or both. There are opportunities to explore similarities and differences. Presented by an account of caring activities most nurses or midwives will recognise features in common. For example:

> *'The student nurse (mental health branch) is within three months of completing her course. Today she is being formally assessed for the 'management component' of the curriculum; the culmination of the continuous assessment of practice. This will entail her effectively taking charge of the ward, organising the workload and making the relevant*



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*decisions in relation to care. Following handover from the night staff, the student conducts a drug round with her assessor, the remainder of the staff are occupied with the care which she has assigned to them and the student prepares for the psychiatric 'ward round'. This is conducted as a series of mini case-conferences in a room off the ward. The student has to use her clinical judgement to determine the most appropriate sequence and present each patient in turn, describing their nursing care and progress to date. Multidisciplinary input and contributions from patient, family and friends involved is sought. The consultant psychiatrist summarises these findings, using them to determine the continuing treatment required. The student ensures all relevant notes and any documentation needed for follow-up are available, and that the patients who have been seen are given appropriate support on their return to the ward. On completion of the 'round', the assessor confirms to her that she has done well and passed her assessment.'* (Vignette 5)

Some aspects of management, communication, making judgements and so on can be said to be similar. What is critical, however, are the differences. The most obvious way in which types of nursing and midwifery differ from each other is in relation to the field-specific theoretical knowledge each employs. But within and between fields there are many other indicators of difference. Theatre nurses not only require different theoretical knowledge from community children's nurses and hospice-based palliative care nurses but they actually do their jobs in different ways. The technical skills required of a triage nurse in a busy A&E department, an intensive care nurse in a state-of-the art medical unit and a practice nurse in a rural GP surgery differ sufficiently to bring about a different sort of doing in each environment. What practitioners do is never a context-free generalised version of practice but instead a form of the practice that works in a given context.

Because different types of context demand different knowledge and different ways of doing and being, no single thing can be considered the definitive version of clinical practice. Nursing and midwifery are blanket terms for a complex of related but significantly different types of practice. And if nursing and midwifery are multiple sets of practices, simplistic notions of level that apply across all practice specialisms become problematic. One response to this is to engage in what was described in Chapter 1 as master curricula. Here reflection falls into detailed surveillance. For example:

*'This is a formal assessment of a recently-appointed practice nurse conducted by an 'accredited trainer' who is an experienced practice nurse with a degree in nursing practice, and has completed diploma studies in asthma care and diabetes and the ENB family planning course. She is employed full-time in a rural general practice but has one day per week of her time funded by the local community trust to act as a trainer. This involves visiting practice nurses at work to ensure that they achieve the range of skills and competencies required by their trust as part of their basic induction programme. It is seen as a form of preceptorship for nurses new to general practice or to the geographical area. Additionally, the trainer's role encompasses a career development focus, with the responsibility for encouraging practice nurses to access other relevant continuing education. The trainer acts as an assessor on various BSc Community nursing modules, and feels strongly that identification and fulfilment of longer-term aims should be compulsory. As it is, there is little to prevent a practice outside the scheme from employing a nurse, for example following a career break, and expecting her to perform whatever skills are deemed necessary, with a minimum of preparation and little opportunity to be away from the practice to attend study days.*

*Aspects of practice which are formally assessed are divided into core mandatory clinical or administrative competencies, with each practice within the scheme able to select a further number of specific competencies according to client group need and GP interest. Today's assessment is of the core clinical skills for cervical cytology. Each nurse is only covered for indemnity purposes in the practice where she is employed. This imposes an element of constraint upon the trainer who is prevented from giving hands-on teaching other than in her own practice, and upon the students who similarly are unable to practise on patients from another GP caseload. Theoretical teaching around the specific skill is followed by observation of practice in the trainer's workplace until the student feels confident to undertake the procedure herself in her practice, whereupon the trainer can only observe, question and continue to instruct verbally. Again, the efficacy of the training depends upon the support and co-operation of the GPs served by this trust: the system would fail in areas where practice nurses are given less preparation or GPs are reluctant to allow them to acquire clinical expertise.*

*Observed by the trainer (assessor), a practice nurse explains to the patient the procedure for taking a cervical smear, checking her identity and details of the date and result of her previous test. She positions her on the examination couch with her knees raised and legs splayed apart prior to insertion of the vaginal speculum. She puts on surgical gloves and warms the speculum under the hot water tap, testing the metal for heat against the back of her gloved hand. She inserts the speculum and positions the angle-poise lamp to enable her to carry out a full visual survey of the area prior to taking the smear. The wooden spatula is inserted to be drawn across the cervix as required. The smear is then transferred to the glass slide and a fixative applied. The nurse has another look at the cervix, indicating a small abrasion to the trainer, explaining to the patient that she has a small cervical erosion. She questions her for any relevant history, dyspareunia or bleeding between menstrual cycles and reassures the patient, after ensuring that she knows what to do should she experience any untoward symptoms. She tells the patient when the result of the smear will be known and the best time for a follow-up in view of today's findings. The patient appears content with this and leaves. The practice nurse clears her equipment, disposing of soiled items safely, and completes the labelling of the specimen and accompanying documentation. Following discussion with her student about the examination just conducted and the significance of the altered physiology, the trainer concludes this assessment, signing the nurse's training schedule accordingly: 'competence in performing cervical smears achieved'* (Researcher's field-notes 10)

Here, assessment is directed towards the minutiae of a procedure. It is appropriate for the purpose. The assessment is carried out as a tactical-level, case-specific task. There is no inquiry at a strategic level, consideration of principles and rationales or contextual analysis and critique. Could this be considered as advanced practice or as extending basic practice to meet specific circumstances for a particular employment role? If it is advanced practice, then presumably advanced practice is no more than the agglomeration of 'bits'. If advanced practice is to mean more than this, more important in assessment terms is how the particularities of practice relate to organising principles, the development of strategies to articulate those principles, and the appropriate tactics to accomplish desired outcomes within a range of circumstances.

Phillips et al. (1996) developed a model of decision making that explored the way in which changing contexts changed the range of options open to the decision maker. It was argued that identifying an appropriate context was critical in identifying the tactical options

open to the decision maker. Such a model enables challenges to be made to views of a situation that claim that no change is possible. The remainder of this chapter argues that the model can be expanded to provide insights into the development of practice-relevant curricula and assessment strategies. Each domain is a particular way of framing the contexts of action in terms of key underlying principles. The practical domain conceives of contexts only as they directly shape action around a set of pragmatically-defined outcomes which focus on particularities that resemble similar cases, situations, circumstances recalled either from experience or cases accessed from the literature. Section 8.3 reframes practical experience in terms of the intellectual domain.

## 8.3 The intellectual domain ('thinking', 'knowing' and 'understanding')

Development to a higher level is typically envisaged as an ability to embrace a wider perspective, informed by experience, imagination and reading. The higher-level student in this domain is able to make imaginative leaps from the particular to the general and back again.

> *'For example, health promotion and empowering people, unless you've done a course you don't have that. prior to this course [on health promotion], for a child with a burn, [I was concerned with] safety issues … very on-the-surface things. But now you might think of the population they're living in, their access to health care, their economic situation.'*
> (Degree student)

For this student the writing demanded by the programme is a means to both an educational and a practical end. It promotes understanding which leads to action, as she points out.

> *'It would change my perspective of that family in the way I respond to them, whereas someone without the academic theory … I would be able to work more with the family. I would look into it more, ring the health visitor, find other sources of help, find out how many other children there are, think around it a bit more.'*

What is changing for her is her awareness of the range of possible actions in response to a particular instance of the theorised cases she has encountered. As she puts it herself:

> *'I've always known what I needed to learn in terms of my practical learning need, like taking blood from a Hickman line, but I didn't know the theory enough to know what I needed [in terms of theory].'*

Essentially, she is developing a disposition to seek out possibilities and to find alternatives.

The process outlined in the extracts quoted can be more generally modelled as follows: a student is presented with a particular case (Figure 8.1); this may be the first time the student has ever seen such a case and thus has no prior experience or literature to draw upon. Her assessor is likely to have seen many similar cases (c1, c2 etc.). Drawing upon experience the assessor may describe a previous similar case, c2, as most like the current case. In c2 a particular solution or course of action was effective. Hence, the same set of procedures could be applied in the current case. Alternatively, the assessor may just say 'what you do is …', giving the student no access to the reasoning behind the instruction. A practice-base curriculum requires the elaboration of reasoning. In order to elaborate a curriculum and its related assessment strategy a fuller analysis of the circumstances facing the student and the contexts of the case must be taken into account. Through self-reflection students can identify their own personal circumstances. This will involve identifying what they know and do not know, their current skills and what needs to be developed, their feelings, their values and so on. Self-reflection recorded in a diary can be tailored to identify key learning needs. The diary may also be the prime fieldwork tool where descriptions of a particular day in the clinical area act as the basis for



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the development of analytic and theoretic memos. By shifting the context of reflection from the *self* towards the *department* and *institutional* ethos, students can explore the philosophies, cultural values and practices, organisational roles, relationships, mechanisms and procedures that frame professional practice. The widening of context is limited only by imagination and time. Each shift of focus may add further options for action that can be undertaken in response to a given case, and can contribute to the development of a curriculum and assessment strategy tailored to the student, the practice circumstances and the theory/practice appropriate to professional development. It can indeed, contribute to thinking about academic and practice levels as an integrated process.

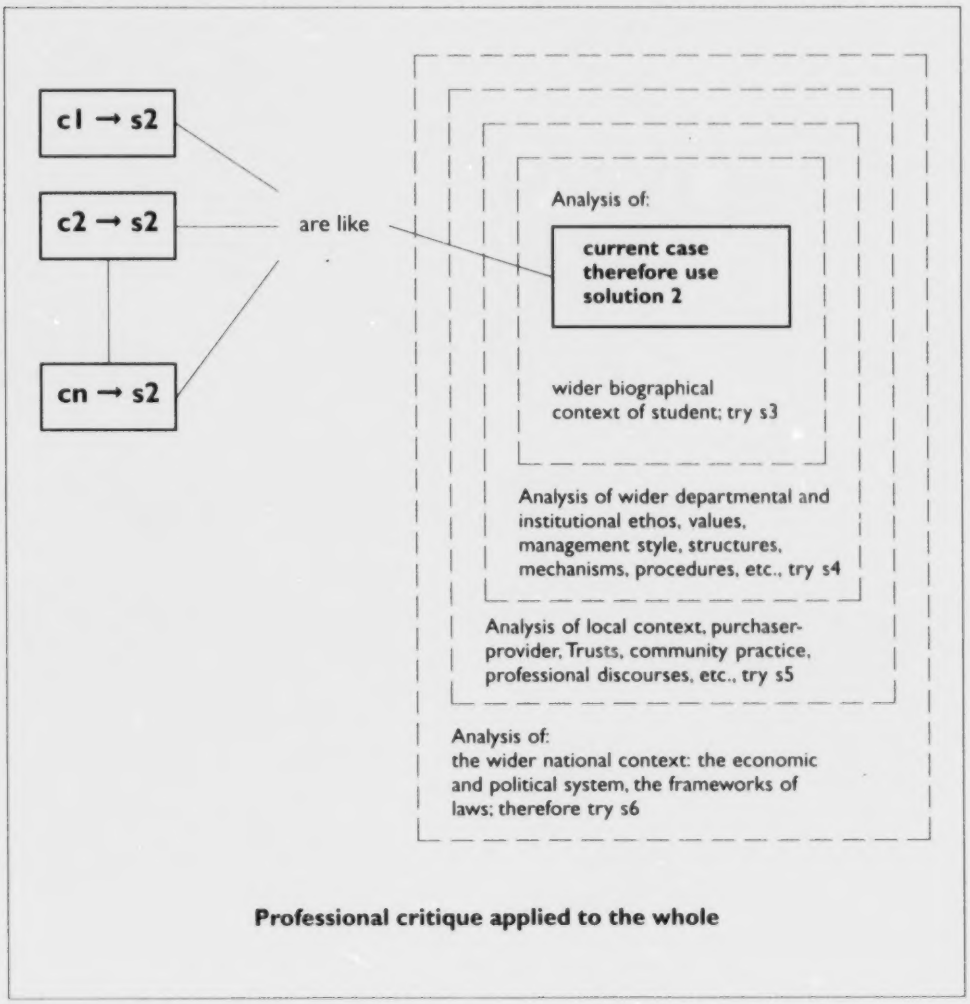


Figure 8.1: The analysis process in clinical cases (Phillips et al., 1996)

This model provides a way of thinking through the issue of levels. Is it the case that Level 1, say, would focus on particular skills rather than the rationales as to why a particular technique should be selected? Thus the student would learn log-rolling as a discrete skill, whereas Level 2 would begin the process of case analysis, and Level 3 would increase the scope through contextual analyses, as envisaged by the following commentator:

> *'The skill basis of practice would not be different [for diploma and degree students]. You would still be expecting competence on completion of that allocation. It would be how they used theory to inform practice that would differ.'* (Midwifery lecturer)

Few interviewees dispute the claim that professional practice requires a good level of intellectual ability. UKCC and Board rhetoric, mirrored in validation documents from the majority of educational institutions, lay great store by activities such as reflection, analysis and critical analysis. These are cognitive activities. Assessment documents often refer to knowledge and understanding, associating movement from (say) Level 2 practice to Level 4 with both increased *knowledge* and increased *understanding through analysis*, drawing on the knowledge. So do practitioners and assessors. How then are diploma and degree levels differentiated?

> *'Very difficult … they would be set psychomotor skills that would be expected of any student but it is how they actually would approach problem solving in clinical practice. This is how we differentiate between the two programmes [diploma and degree]. Their ability to problem solve within the clinical setting. The skill basis of practice would not be different. You would still be expecting competence on completion of that allocation. It would be how they used theory to inform practice that would differ.'* (Nursing lecturer)

Referring to Figure 8.1, it seems that the differences involve increasing theorisation of the case, taking a problem-solving approach to the clinical work. What differentiates levels of practice is movement from just doing (technical skills, psychomotor skills, implementation) to thinking about the doing (problem-solving, assessment, evaluation). This seems to involve a recourse to theory related to case instances rather than an increasing focus on contextualisation in the manner described in the model:

> *'I remember having the argument with colleagues when we first doing the diploma, and even before, the certificate curriculum, my argument was they should start with implementation, move to problem solving, and the move to assessment and then move to evaluation. Just because the stages of the process were like that you started at the beginning, you started at the lowest level skill which was the implementation and then you moved up the difficulty.'* (Curriculum co-ordinator)

> *'Again, talking to the ward staff, well how do you assess degree level in practice, and this is the same debate when we started the diploma course because they were saying to us what is different about diploma-level practice and I think the debate we had is that if you are talking about technical level skills, the physical or doing skills, then there is no difference and these skills have to be the same and they are either safe or not safe. The difference we felt was the level of knowledge and understanding that was used so that all three groups of people should be competent at the technical skills and be able to do those safely but the difference will lie in the application and understanding and the ability to evaluate.'* (Liaison tutor)

Each person defines progress to a higher level as a greater intellectual engagement. All seem to have accepted that there will be no difference in observable clinical action, appear to believe that accessing processes of knowledge selection and decision making in practical contexts is unproblematic. This is in marked contrast to the model described above where each change in context increases the range of options for courses of action whether in the short (now), medium (alternative now) or long (potential future) term. This model enables the assessee to demonstrate thinking and action at both tactical and strategic levels in the short, medium and long terms. Each contextual reanalysis provides a different way of theorising what is at issue, the key circumstances and the key principles (Chapter 6).

This can be further illustrated by Figure 8.2. The shaded circles represent a number of 'observables', whether tasks, techniques or psychomotor skills, in effect the *circumstances of the situation*. Depending upon the understanding or interpretation of the observer, different ways of seeing relations between the elements will produce different theories by which to explain

and understand the state of affairs which in turn will have an implication for the courses of action chosen by the actor. Theory 1 may give rise to a course of action that inadequately takes into account factors seen in terms of Theory 3. Or, Theory 3 may provide an over-ambitious and misleading interpretation of the relations between all the observable factors and so lead to inappropriate action.

If these related to three possible theories underpinning action by three different students, how might an assessor rank them? Each had elements in common. Would that mean each should be marked according to some assessment of 'proportion' of correctness at a theoretical level alone, or should some importance be given to action in practice? Or could the three theories be evidence of the kind of the moving baseline described earlier?

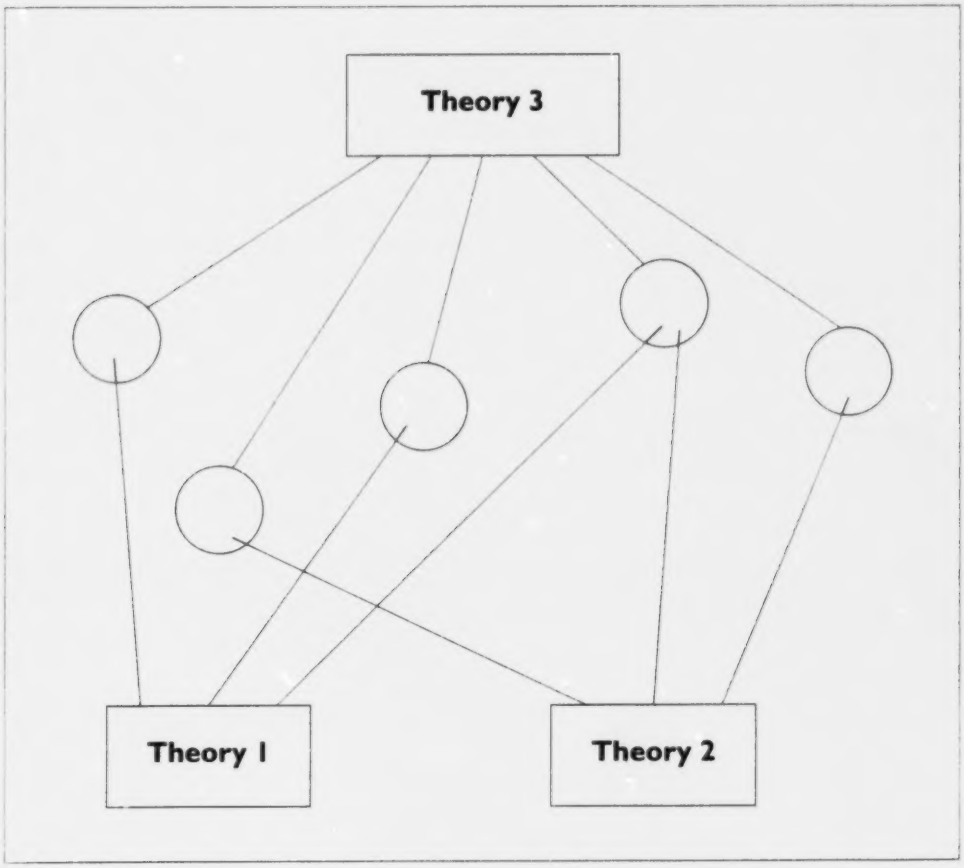


Figure 8.2: How contextual reanalysis provides a different way of theorising

The student's (and perhaps the assessor's) process of theorising could relatively easily be made accessible for assessment purposes through the device of constructing memos to record ongoing theory development, analysis, speculation, strategies for testing theories or accessing further information. Such a process may provide a deeper insight into the thinking processes of the student and would also be available for independent re-examination. These memos may be of two types.

### 8.3.1 Analytic memos

Here the function is to generate potential categories by which to describe the circumstances of a situation. Students would need to explore the relationship between methods of data collection and their implications for recording and categorising data. Thus in dealing with methods involving the quantitative formation, collection and representation of data, students need to explore the assumptions upon which the quantitative methods depend.

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### 8.3.2 Theoretical memos

Here the function is to generate theory that may provide explanations and understandings. The theories then can be used to guide further exploration by identifying gaps in information and knowledge, skills and competence and gaps in understandings. These various 'lacks' may require either field work focusing on interviewing, observing and collecting documentation, or literature searches.

Reviewing such memos student and assessor can negotiate practice-relevant curricula. Assessment strategies then need to be constructed that are directed towards each aspect of the agreed practice curriculum. In the models so far described, dialogue is critical. In order to identify the range of theories and models held by practitioners and those found in the research literature it is essential that students preserve the multiple viewpoints of practitioners and researchers in the collection of evidence and in the ways they represent the practice environment as a case to be explained and understood through theory. Narrative case records (Schostak, 1985) and vignettes (Chapters 6 and 9) can provide the textual frameworks appropriate to representing complex cases capable of multiple interpretation and use in the formation of judgement for professional practice. Current assessment practices do more to cloud judgement than clarify it. As the quotation below shows, uncertainty is cloaked in terminology that suggest a high degree of precision, and assessors are mesmerised into believing they all see the same thing, that they are applying common standards:

> *'For both groups of students they have to meet the requirements for practice to enable them to register as midwives on exiting the programme. For Level 3 practice we would be looking for the critical evaluative skills, analytical skills more than at diploma level although we would still expect some analytical skills at diploma level. Level 3 equals graduate, Level 2 equals diploma, Level 1 equals certificate.'* (Lecturer)

The juxtaposition of references to critique, evaluation, and analysis with very general comparatives and quantifiers like *'more than (at diploma level)'* and *'some'* is illuminative. The first set of terms refers to highly specific intellectual skills, the second makes them relative and non-specific. Not only is there no suggestion that there might be observable differences in clinical skills at the various levels mentioned but the criteria for attributing intellectual engagement are poorly defined.

Linking intellectual engagement to practice levels does not ensure valid and reliable assessment. Symbolically it does raise the status of practice by indicating that it too involves intellectual work, but assessments of theory-practice interactivity in the practice environment cannot be said to be well informed.

## 8.4 Dialogic definitions of level, and the validity/reliability issue

While many university departments continue to seek for better levels descriptors that fit with current academic ideas about quality, apparently in the belief that solutions lie in improving what is currently available (from the premise: 'if the measuring tape is graduated in sufficiently fine units it will be possible to measure the distance travelled to the precise millimetre'), there are some excellent examples of collaborative curriculum and assessment planning which start from the realisation that each side sees things in a different way.

Collaborative groups bring together mentors and service managers, meet regularly to investigate areas of misunderstanding and identify things on which they agree. Levels criteria commonly feature in such discussions. The documents which grow out of more successful discussions offer new ways of looking at levels of practice.

Within-practice development can occur at diploma, undergraduate or Masters level, within any area of specialist practice or as part of generic nursing. It appears to be facilitated

when staff have opportunities to experience practice from as many angles as possible, across the domain of hands-on practice.

> *'We're basically saying training doesn't equal a course. To try and free up people's heads we've got project work, we have short-term secondments, there's a whole range of ways we're trying to loosen up the notion of learning ... mentoring, work-shadowing, short-term secondments, exchanges particularly with the private [sector] ....'* (Programme co-ordinator)

Opportunities like those described provide practitioners and students with an increased repertoire of cases, contexts and scenarios on which to base hands-on practice and to avoid moving out of practice, while at the same time contributing to their chances of developing to an advanced level within the intellectual domain. Such opportunities demand time and organisation for dialogue to take place.

## 8.5 Designing dialogic curriculum and assessment

Constructing explanations to guide decision making in the everyday world does not take the same form as decision making under controlled conditions such as simulations (Chapter 4). There are contrasting approaches to the formation of explanations and understandings. At one pole is the positivistic form advocated by Hempel (1965) that seeks to find universal laws independent of human motivation and intention that has resulted in the 'covering law theory of explanation'; this may result in curricula that emphasise procedures and the recall of factual information. At the other is an approach advocated by von Wright (1971) that focuses upon the motivations, interpretations and intentions of decision-makers. It is not the case that one is wrong and the other is right, but more that both are relevant only within their appropriate spheres of action and purposes. This chapter has emphasised the role of human intentionality since its prime focus is the clinical context rather than the laboratory with its emphasis on controlled circumstances. However, the quantitative and laboratory forms should be included in the full range of possibilities for curriculum exploration as another voice or perspective to be engaged in dialogue. The potential for dialogue and critique is always present but often not fully realised, as a number of the vignettes in Chapter 9 reveal.

As described earlier, in each domain, practical reasoning, curriculum development and assessment strategies involve the analysis of cases, contexts and scenarios. The task is to formulate a design appropriate to clinical settings and the development of professionals. For example, the elements of such a plan may include:

1. **Mapping of circumstances by**

- describing resources
- describing organisational structures and processes
  - routines
  - procedures
  - mechanisms
- describing the range of actors:
  - staff
  - patients
  - others.

2. **Critical exploration of principles of understanding, explanation and organisation**

- through interviews the mental maps by which professionals make sense of their experiences can be analysed

- documentation can reveal the key formal categories, philosophies and visions expressed by organisations
- observation can compare what is said with what is done.

3. **Formulation of strategic and tactical rationales and agendas by which philosophies of care are put into practice**

- at a strategic level, the adoption of key principles and philosophies underpinning care and management in a given clinical area and/or institution can be identified and stated
- at a tactical level, the use of particular methods and resources to achieve the aims of different groups of actors can be analysed.

4. **Critical exploration of selection criteria**

- this can be accomplished at an analytic level through knowledge of appropriate disciplines or perspectives such as philosophy, sociology and so on
- criteria will also need to be explored at ethical and political levels in terms of such issues as social justice, freedom, social responsibility and so on.

5. **Preparing for action**

- rationales for action can be made explicit by drawing on:
  - fieldwork data relating to a specific case or cases and their context(s)
  - relevant research literature
  - discipline based and other academic as well as ethical analyses
- gaining support to practice techniques, skills and so on.

6. **Action**

- implementation
  - under guidance
  - alone
    - observed
    - unobserved
- recording implementation by:
  - notes taken, documentation filled out
  - video
  - development of narrative records, vignettes
  - etc.

7. **Evaluation of courses undertaken – the whole process of exploration and analysis begins over with a focus on the action undertaken and its consequences.**

The whole process is grounded in research, dialogue with key facilitators (mentors, assessors, other students, lecturers etc.) and appropriate literature. The educational strategy would be to identify the ways in which taken-for-granted understandings and explanations can be challenged. Assessment would focus on the rationales provided by students for their analyses, critiques and courses of action. Levels can be identified, for example, in relation to the scope and coherence of the analyses, critiques and actions undertaken. The precise approach to develop such practice based curricula and assessment strategies, would of course, be another project. Chapter 9 provides a number of vignette-based analyses which go some way towards this endeavour.

## 8.6 Summary

The concept of levels is not applied to practice in the same way it is to the academic. Practitioner-assessors and lecturers often have different sets of criteria; both are aware of the need to differentiate between good and excellent practitioners but approach the decision-making differently. Many assessors do not believe there is any observable difference in practice between a good and an excellent nurse, some feel there is and it can be seen in the scope of their practice. We have heard accounts which suggest practice levels are related to two key domains, the practice and the intellectual, which are in a parallel, not a hierarchical, relationship. Curriculum and assessment strategies, if they are to be relevant to clinical practice and the development of high-quality professionals, must be designed to take into account the complexities, uncertainties and real circumstances of practice. This in turn will have considerable resource implications.

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## 9.1 The vignette as a form of educational case study

Chapter 7 began to explore possible alternatives to the portfolio for assessing theory and practice together, proposing that situated understanding and located practice were best assessed in contexts of action in the clinical practice workplace. It was also recognised that practice demands considerable time and attention, with the consequence that much assessment had become *ad hoc*, informal and incidental. In Chapter 6 it was suggested that assessment should be carried out systematically in the workplace, with assessors properly trained and supported to recognise situated understanding and competence for 'now', 'alternative now' and 'future' practice. In Chapter 7 this insistence on *in situ* assessment was not diluted when modifications to portfolios to enable them to be used both outside and inside the practice environment were considered. The final sections of Chapter 7 began to explore the use of vignettes to perform two functions:

- as a narrative component of the portfolio
- as a way of documenting practice itself in a form that could be examined analytically close to the practice event.

The research team found it convenient to construct vignettes as a way of recording fieldwork observations. Some of these have been used to focus attention on the nature of work in the clinical workplace and on the dilemmas individual practitioners and/or their assessors faced on particular occasions.

This chapter uses a number of other vignettes to illustrate how the data were constructed, indicate the enacted theory and situated understanding that was/can be picked out in analysis, and show how competence for 'now', 'alternative now' and the 'future' were/can be identified.

Vignettes are a useful way of making concrete the events and experience of practice, facilitating the identification of individuals' situated understanding and practical theory. They are equally valuable as a means of capturing assessment practice so that it can be reflected on for evidence of both the assessor's and the assessee's enacted theories of assessment. The vignette can be employed in both ways to improve assessment; first to enable assessor/assessee dialogue and second to promote assessor/assessor dialogue in assessor training.

## 9.2 The function of educational case study

According to Walton (1992) *'The universe is inferred from the case'*, but as Becker (1992) pointed out, in order to reason from the case we know (the one we have represented) to the broader picture, we must ask: *'What kind of an organisation could accommodate a part like this? What would the rest of the organisation have to look like for this part to be what it is? What would the whole story have to be for this step to occur as we have seen it occur?'*

Behind Becker's argument is the belief that cases, although in one sense unique, are also particular instances of a socially-constructed world. Thus, the wider social context provides a context for understanding the particular, while the particular can be more fully understood in relation to the wider context.

Each of the vignettes presented below captures a set of unique roles, relationships and circumstances within a particular unique context. Those contexts occur in a wide range and variety of clinical institutions (environments) throughout England. Each vignette records an instance within the same national context, however, and shares with the others the social, economic, political, educational and assessment frames of that context. It is generalisable to the

extent that it reveals principles about the structures for transforming assessment rhetoric into assessment reality in any clinical practice setting in England.

Each vignette offers an insight into *'significant lines of relation'* between its key factors (Blumer, 1969): it is not intended to establish causal relationships. It is constructed in a narrative form that invites exploration through movement beyond the bounds of the particular on which it focuses. It enables imaginative generalisation by bringing 'universals' into focus through the particular. In phenomenological terms it facilitates the variation of circumstances and phenomena in order to draw out or identify those features that do not change under a process of systematic variation.

As each of the vignettes are analysed, we are entering into dialogue around a working hypothesis – a *working* hypothesis rather than definitive statement because what is being examined is a description of a situation in a fluid health care world. This allows the exploration of intentional relationships that focus on the human judgement and purposes underlying courses of action to produce the desired outcomes.

The story in a vignette, and the working hypothesis that comes from its analysis, cannot be simply *transferred* to other situations; they must be recreated for the new situation. The new situation will be a subtly varied version of the first, which may embody similar universals but will differ from the first situation because universals must be understood in relation to each new set of particulars. Illustrative vignettes are envisaged as being used for assessment as a starting point for the construction of personalised vignettes of 'my/our' practice, through which working hypotheses about situated understanding, enacted theory, choice, dilemma, judgement, etc. can be examined.

The vignette representations each tell what happened within a specific, physically-bounded clinical environment on a particular day during the research. At the same time they are part of a larger, more encompassing story about the professional development of nurses and midwives in the NHS. They are cases in their own right and also part of a larger case with wider social, professional and cultural boundaries.

There is always something of a dilemma in determining what it is that the case being studied is a case of. Becker (1986) argued that good research cannot answer the question at the beginning. One of the advantages of a vignette is that it represents a composite of viewpoints to represent something immediately recognisable, concrete and verifiable from evidence, but what it is *precisely* a case of is still open for discussion and exploration. As a composite it provides or preserves a range of alternatives and hence grounds the possibility for educational debate. Although collectively the vignettes which follow represent the case of nursing/midwifery practice assessment, individually they are still open for discussion over what they are a case of. This is one of the strengths of the vignette.

## 9.3 Vignettes of formal assessment events

### 9.3.1 Assessment as allocation to categories in an assessment schedule

The location is an oncology unit in a large general hospital. A preceptor and an experienced staff nurse are talking together in the staff room just off the ward. The staff nurse is taking a post-registration diploma.

> *'The preceptor/assessor is an experienced cancer nurse specialist and the nurse being assessed is a mature RGN recently appointed as staff nurse in the chemotherapy ward. She has no previous specialist experience in oncological nursing. They are meeting as part of the ongoing assessment of practice and will work from an assessment document which the nurse filled in earlier in preparation for this formal assessment.*

*The first section of the assessment document records biographical details. In the next section, 'self-awareness', she has attempted to identify her personal strengths. She and the preceptor explore how her own experience of cancer may facilitate discussion and empathy with her patients and consider the possible risk of excessive emotional involvement and stress. They talk for a few minutes about what she might do to avoid stress, discuss her knowledge of treatments – concentrating on the physical and emotional changes which can occur during a course of chemotherapy, and agree that her knowledge here is a strength. They then look at elements of the nurse's knowledge which, in the words of the preceptor, 'require further input'. She feels she wants more guidance about medical research and her expected involvement with this. An animated discussion ensues during which the preceptor elicits what the nurse already knows about ethical committee protocol and approval, building upon this to provide further information.*

*The discussion moves to the next section, headed 'clinical skills'. The nurse has identified what she takes to be her areas of competence, listing (a) providing effective general nursing care and (b) providing support for patients who are able to maintain greater levels of independence. She then adds a range of specific skills, including (c) care of patients undergoing intravenous infusion and drug administration (d) the prevention of cross-infection and (e) accurate record-keeping. The preceptor leads a discussion to explore her knowledge of data-protection issues, the auditing process and the role of the UKCC in relation to record-keeping. The nurse had identified cannulation as a primary area of skill to be developed during these first six months in oncology, and confirms her subsequent completion of short programmes in venepuncture and cannulation. She reports that she performed five of these procedures under supervision and had been deemed competent, but had felt that this was insufficient experience so had actively undertaken to perform more before getting her clinical supervisor to sign that she was proficient.*

*The preceptor temporarily reverts to her role as the nurse's manager, stressing the importance of ensuring that she continues to cannulate regularly to maintain her efficiency. She says that the nurse should include this as an element in her annual performance review. She then becomes assessor again, endorsing the judgement made by the nurse's clinical supervisor within the ward by writing a comment that records satisfactory involvement in a range of activities.*

*Further sub-headings identify the nurse's performance in relation to teaching skills, managerial potential, counselling, advocacy and 'research-based practice'. The nurse feels that, as an experienced practitioner, she has already demonstrated her ability to teach patients and colleagues and has used a variety of health-promotional material, but needs to be able to relate this to oncology.*

*Similarly, she feels that her management ability, advocacy and counselling skills are well-developed, and agrees with her preceptor that these should be transferable competencies. The nurse cites an example from her current practice demonstrating the potential for an advocacy role in relation to patients' participation in clinical trials, discussing how she can incorporate and develop this further; and again, her preceptor adopts a managerial stance in identifying this as a target for next year's performance review.*

*Reviewing the last subheading, the nurse was uncertain what to include. 'Just what counts as research-based practice?' she asks. The preceptor's response was that, as a unit, they were only working towards this, using documented nursing summaries, and video-recording some clinical trials with which they were involved. 'The way it has been incorporated into the business plan means we must all be research-aware to survive in a unit which is so dependent upon medical research,' the preceptor says.*

*The next section of the assessment documentation is devoted to the learning contract negotiated and updated throughout the preceptorship period. The nurse is anxious to learn more about different patterns of drug administration, and care and safety aspects involved in the use of cytotoxic materials. They talk for a while about the different treatment regimens favoured by consultants in the unit.*

*When they come to the heading, 'research' both assessor and assessee show irritation. 'Surely we've already dealt with this!' At this point they begin to discuss the assessment document itself, agreeing that it is 'far too long, repetitive and time-consuming'.*

*The session continues for two hours, exploring the nurse's progress in the chemotherapy ward. The preceptor performs her role as assessor conscientiously and is supportive of the nurse, who in turn has prepared her assessment form thoroughly, using it to identify areas for further development.'* (Vignette 7)

In this vignette the assessor/preceptor is evaluating her mature assessee's practical competence by discussing it outside the context of action. There is discussion about the knowledge the assessee has and the knowledge she lacks. The assessor offers some immediate teaching on data protection, audit and record-keeping and ethics committee requirements. She also offers a definition of research-based practice.

This is a typical sympathetic formal assessment. It is conscientious and painstaking, and works closely to the official assessment document. It is also unreliable as a means of assessing competence to practice in the context for which the assessee is preparing. It does nothing to prepare her for changing versions of the context.

At no point is the assessee assessed doing the job. In fact, the assessor relies on second-hand information about the assessee's clinical practice, in the form of a verbal report that it has been approved by her clinical supervisor. Despite the two-hour discussion the assessor eventually resorts to the equivalent of a tick. The discussion (and document) construct the assessment activity primarily as a knowledge/skill checklist designed to identify 'what I can do' and 'what I can't yet do'. It looks at strengths but appears to be most concerned with identifying deficit and planning for its remediation. This, of course, is sensible: if the nurse is to work safely in oncology she needs to know about drug administration and the use of cytotoxic materials. But by doing the assessment in this way, the assessor constructs issues such as clinical trials (and the procedures used in them) as non-controversial. Equally, they finish up talking about treatment regimens being determined by consultants as if this should be a taken for granted.

In this vignette the assessor helps the assessee identify knowledge and skills she should try to develop. She also looks at the person and encourages her to build on her personal strengths and experiences. She is preparing her well to be 'now' competent.

However, the assessor does not take the opportunity to engage in dialogue that would have revealed how well prepared the assessee was for handling the dilemmas of alternative versions of 'now'. There is no discussion about values and the implications for practice; a strange omission given that the interview takes place in an oncology setting. There is, with the significant exception of discussion about empathy and stress, no attempt to map the problem-

structure of oncology nursing, which is, surely, a place where dilemmas, uncertainties, and difficulties are central components of practice.

The vignette shows clearly the effect assessment through categorically-organised assessment documents has on assessment activity. The assessor and assessee work through an agenda which is organised in a way that both find alienating. It seems repetitive because once they have aired accounts of practice as a way of responding to earlier headings, they have pre-empted many categories still to be completed. How different would the experience have been if the assessor had been able to give half the time to the assessee to explore her experience narratively and the other half to analyse those accounts, only after that assigning what has been discovered to categories?

Finally, of course, this is not an assessment of practice. It could serve a useful purpose in its own right, with modification, but as it is it becomes an activity in which the assessee self-assesses and the assessor becomes the endorser of the assessee's and colleague's views about the practice she (the assessor) has not herself observed.

### 9.3.2 Assessment as a necessary but irksome 'bolt-on' activity

The location is a learning disabilities unit in a district general hospital. The assessor is a ward manager and the assessee a pre-registration diploma student. As with Vignette 7, the event described takes place outside the context of action.

> *'This is a 10-bedded unit for children with complex disabilities. There are many examples of multiple pathology and all the children have moderate to severe learning disabilities. It functions as an assessment unit and offers ongoing crisis and respite care. The assessor is the junior ward manager and students undertaking learning disabilities, child and adolescent care programmes are placed here. Her current assessee is taking the DipHE (learning disabilities) programme, and this is her first branch-specific allocation.*
>
> *It is quiet in the unit and the student and assessor have met to discuss the continuous assessment of her practice. The student appears to have difficulty in interpreting what is required. She asks her assessor to guide her through this. The assessor does this but expresses concern that 'it is difficult sometimes to tell the difference between what is expected for students at different levels – we have them all here'. She points out that she sees students from pre- and post-registration programmes and that within the pre-registration programme there are currently two different curricula.*
>
> *The current student's programme uses the new curriculum and an assessment document which requires completion by the assessee prior to ratification by the assessor. The student is required to write a paragraph to show her level of understanding in relation to each of a series of items, linking theory with practice. Today, she has to provide a paragraph of writing to demonstrate how an understanding of genetics is relevant to her practice. She talks about the task and says that she does not know how to approach the exercise.*
>
> *The assessor leads her through a discussion of the children for whom she has been caring: they include children' with conditions due to some chromosomal anomaly, Down's syndrome, trisomy 13 and Edward's syndrome. They talk about the genetic link, the assessor eliciting a rudimentary level of understanding from the student, who provides an example from an actual family who have cared for two affected siblings.*

*The assessor talks about genetic counselling and invites the student to discuss some of the issues surrounding selective termination of pregnancy. She asserts that it is a nurse's responsibility to support parents' decisions. Following this discussion, the student drafts a paragraph 'demonstrating' her application of theory to practice.*

*During the discussion with the student, the assessor makes critical comments about the assessment document: she says she feels, 'the people in education are working to their own agenda' and that 'neither side understands the different pressures under which each other works'. She reports that it regularly takes over two hours to go through the document with students at the end of an allocation, and that she spends 'considerable chunks of time' discussing what the student has written and she has observed about a nursing intervention.*

*Both assessor and assessee find the document bulky and complain that the content is extremely repetitive: for example, communication skills are assessed as a stand-alone example of 'professional competence', in relation to the multidisciplinary team, in discussion with colleagues, health education and communicating with parents and children. Similar repetition occurs throughout, 'this is patronising to me as a skilled professional'. The student says how 'I have to pester the busy ward staff to complete the document – it's so long'.'* (Vignette 8)

This event takes place away from the practice environment. The assessor is not observing her assessee in practice but talking about how it should be done. They are dealing with the 'normative' version of practice rather than the actual practice with which both are familiar. How might things have been different if she was watching the assessee at work with her patients? How does the assessee's understanding of the genetic accident that means some children are born with Down's syndrome or Edward's syndrome, affect her relationship with her patients? Does it improve her decision-making?

The assessor has, in fact, observed the assessee on several occasions when carrying out particular interventions, and is probably able to draw on this evidence to inform her assessment of the assessee's clinical skill and also her empathy and decision-making. But the document through which they review the assessee's practice does not encourage reference to these other pieces of evidence that come out of practice observation.

Both parties treat the activity as a necessary but unrealistic activity. How reliable is an assessment of communication skill outside the context of interaction, for instance? Is awareness of language of skills sufficient assurance that a person is able to communicate well across a range of contexts? What does 'communicate well' mean, anyway? And what is the purpose of a lengthy document that divides experience into segments? At the very least, its repetitiveness and length alienates those who must use it; at worst it makes them feel, as this assessor does, that much of what they are doing is a waste of time. And if, as the assessor reports, it regularly takes over two hours to go through the document, who can doubt that it is a waste of time.

Could the assessment document have been a focus for examining ethical and value issues? The assessee regularly had to write a paragraph on her practice, and needed to ask the assessor how to construct this. What might have been the difference in understanding if she had been encouraged to write a narrative account and the assessment 'time out' was used to discuss her feelings about improving the quality of people's lives through hospitalisation when compared to modifying their 'defect' through genetic modification? This would have encouraged the assessee to begin mapping the problems of nursing in the context she found herself in, and introduced economic and pragmatic discourses as well as the discourse of utility and convenience. Future health care will require practitioners with a well-thought out view on these issues.

Given the assessees' experience of formal assessments revealed by Vignettes 7 and 8, it is not surprising that one of the students expresses the view that:

*'It's more useful in discussion at handover than writing it down at home.'*

This student has identified that discussion close to practice, or indeed as part of practice, is more useful to her. It relates to a real set of issues about a real set of people.

### 9.3.3 Assessment as direct and systematic observation of practice

Carole, the student being assessed, is a qualified nurse (RGN) undertaking an ENB Care of the Dying programme (931), which may be taken independently but which forms a module of study for a BSc in Nursing. Her assessor, Mary, is a community liaison district nurse who holds a teaching qualification, having worked as a clinical teacher. Her caseload consists primarily of patients from the oncology wards of two district general hospitals, and others with a variety of terminal or life-threatening conditions. Carole is nearing completion of her programme, during which her practice has been the subject of continuous assessment by her clinical supervisor/assessor, with whom she has developed a confident relationship. She must complete a written assignment related to her area of clinical practice, and has sought Mary's advice in relation to the selection of a suitable topic. They are planning to spend some time discussing this later today.

*'They have arranged to meet at the hospice where they will spend the morning reviewing, with the staff, the current care needs and admission patterns of a number of patients. The first of these is a man of 60 with motor-neurone disease, who has recently arrived at the hospice following a period of acute hospital care. He has suffered severe weight loss and is profoundly aware of his altered body image. He would dearly like to put on weight as he feels his appearance is frightening his family and he is afraid of this becoming a barrier between them just when he wants them to be able to communicate freely. He is also contemplating making a 'living will' and would like talk about it with them, but needs to clear his own thoughts about it first. Carole suggests that as he has an Atkinson tube in situ, the use of a peg might be effective in promoting some weight gain, and offers to go back that afternoon to talk through his ideas about a living will, not promising to be a great deal of help but saying that he is at liberty to use her as 'a sounding board'.*

*The second patient is a woman in her 70s with lymphoedema, admitted from hospital, only able to sleep in a chair, increasingly immobile and having great difficulty in washing. Mentally extremely alert and independent, her greatest wish is to return to her own home and her cat. Carole suggests that a care assistant could go in daily to help her when she leaves the hospice, but they should first attempt a home visit with the occupational therapist to determine any aids or adaptations which may be helpful.*

*The third patient is a woman in her 50s who has ovarian cancer with bladder and abdominal secondaries, and whose husband is disabled. She has had a number of hospital admissions and periods of home nursing followed by this recent episode of hospice care, having been assessed by community staff as needing social not nursing care (other than to maintain analgesia by recharging her syringe driver daily).*

*The patient is clearly distraught by what she interprets as a withdrawal of nursing services and relegation to permanent inpatient care. Carole reassures her that her wishes will be taken into account and discusses the*

*concept of an ideal package of care. She points out that this may involve intermittent home care, using a nursing auxiliary for support or domestic support arranged through social services, but retaining daily district nurse input to replenish the syringe driver and monitor her condition. She tells the patient that if she wishes she could receive hospice day care two or three times a week (with transport provided). There could also be longer respite admissions to enable her husband to take a break, 'but you'll want to discuss that with your husband first'.*

*In each of these episodes, the student takes the lead role in initiating discussion and suggesting variations in the organisation and arrangement of care. In doing this, she is supported and encouraged by her assessor and the hospice nursing staff. In turn, they all contribute to the assessment, as the assessor and student asks for their judgement of the way in which she has conducted discussions with the patients and the systems of care she has suggested. They express their pleasure with Carole's handling of the situation and grasp of the principles underlying shared care. They listen to what she says about her written assignment, which she tells them will be called, Devising and Implementing Packages of Care, give ideas for her to consider, and tell her that it will be a topic that 'will raise a few questions'. They are very supportive of her approach.'* (Vignette 9)

This is a different sort of formal assessment from the previous two. There will be a discussion away from practice later, so the situation depicted in the vignette is not used to replace the discussion. Rather, it is to complement it with direct and systematic observation of the assessee in practice. The assessee, has spent a considerable amount of time with her assessor on a one-to-one basis. This has been possible because of the individual nurse-to-patient relationship of community nursing. Mary, nevertheless, arranges to see how Carole fares in a hospital situation.

This deliberate translation to another situation enables Mary to assess how Carole draws on her situated understanding of community nursing for a parallel but different situation. For a morning, Mary has left her district nurse role and taken an (almost) exclusively assessor role. She is working alongside Carole where she can see immediately how she puts her theory into action, or, more accurately, enacts it or brings it into being. Carole's theory is informed by technical knowledge but is also enacted as a theory of interpersonal relationships that gives prominence to offering people choice. Even when she has a preferred course of action of her own, she suggests finding what another professional and the patient think when they are able to experience 'being home' (e.g. a home visit with the occupational therapist to discover any aids or adaptations which may be of benefit) and repeatedly draws attention to the fact that the options are not closed.

There is nothing unusual in what Carole does, it is good nursing behaviour and typical of what happens in many discharge interviews. She could have presented each patient with a more limited set of options or, by her demeanour, have implied that the options were entirely limited to the ones she proposed. But Mary and other members of the nursing team see exactly how she negotiates with the patients, which gives them the opportunity to assess the qualitative difference between Carole's theory in action and that of anyone else who may profess the same intentions but do something other in practice.

The assessment is a team effort. As they discuss Carole's practice with her, the team share their decision-making. They indicate the value of a problem-focused approach and make it clear that they are evaluating Carole's proposed assignment with that criterion in mind. The combination of a lived problem-solving approach and a lived triangulation of observational evidence, suggest that this team of informal assessors, together with the formal assessor who has taken a temporary assessor-only role, will arrive at a highly valid and reliable assessment of

Carole's competence. They have, after all, actively checked their judgements through team discussion with the assessee present.

## 9.4 Vignettes of 'informal' observation of practice

### 9.4.1 Assessment as a team activity in the context of 'having to cope'

*'The location is a general medical ward in a suburban general hospital. There are two large bedded areas with male and female bays off. There is also an investigations bay left clear for patients awaiting full diagnosis; this is overseen by a specialist nurse practitioner. There are 28 patients on the ward, including four in the investigations bay. There is an open area for relaxation where patients and staff can sit; it has a video player and videotapes on postoperative care and for various medical conditions. These are available for staff and assessees.*

*There are five qualified nurses and two auxiliaries on duty. They work in two teams but when the need arises, individuals from one team help the other. The ward is visited during the observation by a clinical pharmacist, who is consulted as 'a woman who knows about drugs', and two junior doctors (both women) who spend two-and-a-half hours there. There is an informal, jokey relationship between the ward manager and these junior doctors, which allows the nurses to initiate conversations of the sort that start, 'how did you get on the other night at Sally's?' The ward manager reports, 'The majority of staff do bank nursing as well as their own job … some do this seven days a week … they are on their knees'. Jackie, a post-registration degree student is 'only doing one bank shift per week 'cos anything else would be crazy on top of my studies … but I do have £3,000 worth of student debt to pay off'.*

*During the observation period Jackie is working alone for much of the time. At one point, having just spent time with a patient with diabetes, she seeks out James, a qualified nurse, and asks about the procedure for switching off an insulin drip. She is concerned that she has seen it done in at least two ways. James points out that their patient is on a sliding scale insulin regimen due to vomiting and that this means there must be regular switch-off periods, resulting in 20-minute segments where there is no insulin input. He says, 'this is not a life and death thing, but ['x' way] is slightly safer than ['y' way]'*

*Later, Jackie is asked to bring a patient on a trolley from the post-operative ward. She is asked to do this unaccompanied, despite objecting in a light-hearted way, 'I'm the most junior member of staff, I suppose'.*

*Later still, she is asked to arrange an MSRA check for an elderly female patient about to be transferred to another hospital. Jackie notices that in the nursing notes it says this has already been done. She finds another qualified nurse, who confirms that MSRA checks only have to be done every four days. Jackie decides not to arrange a test.*

*Jackie sees her official assessor during the shift for just three minutes; the assessor is ward manager and must devote a large amount of time to the bed availability problem. For much of the rest of her time she is co-ordinating medical and nursing records with other professionals who visit the ward. She does not get a lunch break until an hour-and-a-half after the time originally planned.'* (Vignette 10)



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This vignette presents a detailed, although selective, account of the writer's perspective on working as an assessee on a particular medical ward in a medium-sized hospital. It provides a 'thick description' of the workplace environment. What are some of the competing agendas it makes evident?

The vignette paints a picture of a place where every member of the clinical team is constantly busy – so busy, in fact, that the assessee rarely sees her assessor and has to seek out staff to proactively ask for help. But it also gives a picture of a place where team members support each other, where it is possible for an assessee to feel like a 'proper' member of that team, and where there is provision for structured self-education (through viewing videotapes). The hope is that at some point there will be sufficient space for time out to allow study. By the same token, that hope is not reflected in the reality, which includes staff so poorly paid that they supplement their basic pay with more lucrative bank work, with consequent stress and fatigue, and a bed allocation so under pressure that all available beds are taken up and acceptable nurse:patient ratios put under threat.

The assessee has clearly developed a practical theory. Part of this is that she should not practice beyond her sphere of competence (her indirect challenge to the request to transport a postoperative patient single-handed). She asks others when she is not sure what to do, especially when she has witnessed different and possibly contradictory procedures (the insulin switch-off), and has a readiness to question practice that seems not to be in the patient's best interest (the MRSA test). Without an observer present to witness these events, those aspects of Jackie's practical theory are likely to go unnoted.

This clinical area appears to have the qualities of a supportive learning environment. Mutual learning is encouraged through teamwork, there is the beginning of a resource for learning through time out close to the workplace, and above all people are valued at the interpersonal level (jokiness, respect for each other's opinions, caring for each other personally as well as professionally) even though, at the wider structural level, resources are so inadequate that staff are under considerable pressure.

### 9.4.2 Assessment as identification of situated understanding through assessee and assessor working together

*'The location is an A&E ward in a general hospital in a coastal town. Only three patients are waiting and they do not appear to have serious injuries. There are 12 curtained bays for examination and a large room where patients can shower or rest on a bed after their first consultation. The ward is staffed by a sister, three staff nurses, a triage nurse and two care assistants. There are two pre-registration degree students on the ward, Diane and Malcolm; Malcolm is in the sixth week of his placement, Diane her second week. Their normal assessor is unwell and they have been allocated to a back-up assessor, Wilma. She is waiting to be interviewed by two other students who are due to arrive in half an hour.*

*After three-quarters of an hour the students have had almost nothing to do. They have spent time talking to the researcher and Malcolm has also studied a set of protocols and a specially-constructed trolley pack. Then an elderly woman presents with chest pain. Diane and Wilma together, but with Wilma taking the leading role, take an ECG to see whether the chest pain is heart-related. When this activity has been completed, Diane is invited to fill in the admission form. 'Diane, would you like to have a go at starting one of these? Don't worry if you make a mistake … I'll help'. Diane goes away for five minutes then brings a half-completed form to Wilma, who advises her how to fill in the blanks. She also advises Diane to get full information about the patient's mobility from the patient*



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*herself. She advises her that 'the property/money section is something they're [management] particularly keen on'. At that moment the students who plan to interview Wilma arrive and she leaves the ward for almost an hour.*

*Diane returns to look at the ECG and says that she thinks there is 'an irregularity … something not quite right'. She shows the ECG to the sister who takes it and Diane to one of the three doctors on the ward to check whether the irregularity is significant. The doctor is uncertain and seeks the opinion of another. He asks the patient's age (which no-one has thought to calculate from the date of birth) and after consulting the patient it is noted that she is 81. It is also known that she has been previously diagnosed with breast cancer. The second doctor goes with Diane to the patient's bay and asks the patient a range of questions about the nature and location of the pain. When they re-emerge he confirms to Diane that she was right to ask questions about the reading; the patient had in fact had a small cardiac infarction.*

*Malcolm, throughout this time has been giving care in conjunction with other staff and has also – on his own – admitted a mental health patient who has self-harmed. He has taken a personal history from the patient and checked availability of support at home for when the patient leaves. He has checked with the patient's care worker whether he has an ECT history. Having completed that he returns to see if he can help Diane but finds she is 'coping well'. He tells her that when he had done a few ECGs he was shown how to do it properly. 'After that, every ECG that came along, she said you can do that now.'*

*Towards the end of the shift both students are shuffled between taking histories from a group of sailors (rescued after several hours in the sea) and making them cups of tea.'* (Vignette 11)

What were the assessees getting from this apparently rich experience? What can we say about the validity and reliability of the assessment they received?

Clearly the fewer clinical demands on staff and assessees the more time there is for educational interaction. In this situation, however, the assessor seems to have over-committed herself, with the result that for some time when she could have been working with her assessees, she is 'doing a favour' for two others. Nevertheless, when she is available, she works alongside her less experienced assessee, guiding her and giving her a chance to do things for herself. She is willing to let her make (non-fatal) mistakes and to learn from them. She has in the past provided access to instruction where there appeared to be a need for further learning. She could have instructed the assessee and then spent time teaching her herself to put right this deficit; instead she chooses to let her try things out and observes her while working with her. She presents the assessee with situations where she has to map problems and make decisions, consequently, as assessor, she is in a position to assess her assessee's ability to do both.

This particular A&E culture appears to foster continuing professional development. A&E activity is typically uneven, with peaks and troughs; Malcolm, who has been on the ward for several weeks, uses troughs to study because the materials are provided to encourage him to do so. It is probable that qualified staff have modelled this behaviour. Conversation about values also took place in these troughs.

Both Malcolm and Diane see themselves as agents in this environment, people who do not have to wait on others for permission. This is part of their practical theory. Diane could have looked at the ECG and thought *'it's none of my business'* but she actually brings it to the attention of another member of staff. She reveals the confidence to question and go beyond the

'now', which has established that an ECG, once read by a doctor is no longer the concern of a nurse, to imagine an alternative where nurses also read ECGs and discuss them with fellow nurses.

The assessor has worked with the assessees and been able to watch them as they put their situated understanding into action. She has also seen what they do at moments of uncertainty. She is in a good position to provide a valid assessment of key aspects of their competence. This is systematic assessment; while it is unlikely to happen when the workload is heaviest, an afternoon of systematic and close working with assessees gives the assessor greater access to their understanding *and its outcome in practice* than 30 minutes (or even two hours) of document filling. Especially, as in this case, when the assessee is part of the clinical team long enough for the assessor to work in this way with them on at least six occasions.

The vignette prompts the following questions. What would be the effect on practice assessment of regular periods of intensive observation (one hour a week, perhaps) rather than a continuous failure to be with the assessee for more than two or three minutes at a time? Where are the practice areas where there is a strong likelihood of troughs for study and dialogue? Is there value in seeking these out as advantageous assessment environments? What taught this particular nurse how to combine an assessor and a carer role? Does the first assessor she replaced go about things in the same way and if not, what effect might that have on the quality of the assessment received by the assessees of each of them? And finally, does the 'see one, do one, and then many more' remark reported by Malcolm indicate that while this is a well-structured environment for 'now', it is less conducive to the development of alternatives for both now and the future?

### 9.4.3 Assessment as an element of reactive, 'now' practice

*'The location is a post- natal ward with 22 beds arranged in three bays of six each and four single side wards. These are used for sick mothers, those who have lost their babies and for any ante-natal patients requiring long-term admission. Because of current staffing difficulties and a particularly severe shortage of midwives, the ante-natal ward (on the next floor) is only open at restricted times. Several members of staff are dissatisfied with what they describe as the unsocial hours, and complain of unpaid overtime in the form of meal breaks not taken. They all feel the pressure acutely; two of the ward team recently left in response to active recruiting from GP practices to become practice nurses.*

*The shift being observed is a 12-hour one (7.30am-8.00pm). The student midwife is working with her assessor, the midwifery sister in charge of the department. This presents a conflict of responsibilities which she acknowledges at the outset, saying that while she is a committed teacher, her first responsibility must be for the clients in her care. The student is an experienced RGN undertaking an 18-month Diploma in Midwifery with the option of completing a further module and a dissertation to gain an honours degree. She is three months into her programme and this is her second clinical placement, the first having been to the delivery floor. She is three weeks into her current allocation and she and her assessor have worked together twice. The student says this is because of shortage of staff and the need to cover the department adequately at all times. 'In this situation student needs come a long way behind and you're just slotted in wherever there is a gap to make up the numbers.'*

*Although she has been on the post-natal ward for three weeks, the student still awaits her initial assessment interview. This will entail completing a booklet in which she identifies the learning objectives she wishes to*

*achieve. She is hoping to do this later today but is conscious that the department is short staffed due to sickness and that her assessor is likely to receive constant interruptions.*

*At 10.30am the student and her assessor have their first opportunity to work together, the assessor having been busy with administrative duties. In the meantime, the student has been helping clients prepare for discharge and assisting new mothers to begin breast feeding. An ante-natal patient has been admitted to one of the side wards; she is expecting twins. The student and assessor see the client together, discuss their findings, reach an agreement which satisfies the assessor, and the student enters this into the case management notes.*

*They discuss the estimation of due date in relation to the height of the fundus, foetal movement and the onset of irregular muscular tightening (as opposed to regular uterine contractions). At this point, the assessor is called away to attend to a post-natal client who has developed an eye infection, several queries involving the duty roster and the problems encountered by a holiday visitor who delivered unexpectedly and only speaks French. On her return, the assessor and student continue their examination, both performing an abdominal palpation and commencing a CTG recording.*

*The assessor asks the student what she has elicited from palpation and they agree that Twin 1 is 'a long lie', cephalic presentation with the head still free and a foetal heart rate of 136, while Twin 2 is also a cephalic presentation but lying obliquely with a foetal heart rate of 145. The assessor says that both babies feel small, given the due date. The student is unaware of the sequence and format to be adopted in entering these data in respect of a twin pregnancy, and the assessor helps her. At this point she is diverted to attend to doctors' queries, is involved in sorting out problems in organising a scan, requesting porters, seeing relatives, arranging two discharges and organising admissions from the delivery floor.*

*Meanwhile, the student assists mothers attempting to breast feed and deals with doctors' queries, finding relevant notes and accompanying the doctors to see clients.*

*By 2.00pm the student has not had her interview and neither she nor her assessor has had lunch. Midwives for the late shift arrive and the assessor sends the student to lunch and prepares to give the handover to oncoming staff. She is prevented from doing so until she has dealt with administrative queries, a telephone enquiry, a search for relevant notes, the organisation of specimens to be taken for culture, and checking a patient's condition prior to discharge.*

*Intravenous antibiotics are now due; all the midwives are busy, and the assessor administers these before commencing a detailed handover. The constant interruptions persist and the handover takes over an hour co complete. With the exception of the student, none of the early shift has been to lunch. The assessor arranges for two to take their break and orders sandwiches for herself, anticipating that the ward will be too busy to leave.*

*By 5.00pm the student has admitted a further patient, assisted with drug administration and accepted a baby discharged from the special care baby unit to be with his mother, applying security tagging under the guidance of her assessor.*

*Despite her reminder twice during the shift, the student and her assessor still have not been able to complete the relevant assessment documentation for the preliminary interview. The condition of the woman with the twin pregnancy is causing concern and the pace of work within shows no sign of relenting.'* (Vignette 12)

The assessee already has experience as a nurse so she will have a theory of practice as *'survival'* and as *'doing the best you can under the (often impossible) circumstances'*. Three months into her programme, in this post-natal unit, she is having that theory confirmed for midwifery. What will she learn to become? Is there any possibility of her developing 'future competence' in the face of this unrelenting busyness?

Unwittingly, the assessor is modelling both midwifery and assessment as reactive response to immediate demands. Everything goes on hold to deal with the current requirement, which is soon followed by another, so the work is experienced as a series of interruptions. There is little or no time to reflect on alternatives, no opportunity to make changes to the organisation to facilitate forward planning or assessment. The assessor's reactive midwifery is partly a product of the situation, with limited staff resources and high bed occupancy, but also partly because past experience has led her to expect to work this way. She appears to expect interruption and always prioritises the latest one. Might there have been times she could have put something other than the assessee's needs on hold? What would be the difference if this assessor, like the one in Vignette 9, officially stepped out of her midwifery role for an hour to observe the assessee in action? The assessee has been using her knowledge and skill to assist breast-feeding mothers and mediate doctor-client events; if the assessor had been able to observe this she would have had access to the assessee's situated understanding and the basis of a dialogue about it.

The overworked assessor has no time to see what the assessee was doing under her own initiative. She sees her briefly twice when they work together, making a care plan for the woman expecting twins and tagging a baby. Because of this, she acquires first-hand evidence of the assessee's knowledge and skill with respect to palpating, monitoring a heart rate, wrist-tagging, etc. This is important 'now' competence, which comes about partly because the assessor has directly taught the assessee to fill the deficit in her knowledge, e.g. in filling in a form when the details of twins are to be recorded. But the assessor has no opportunity to see situations where the assessee has to make a difficult choice. She is unable, because of the circumstances, to assess the assessee's competence to imagine alternatives or practice in ways that will prepare her for the future.

Given the circumstances on the ward, the assessee could not be blamed for believing there are *no* alternatives; that this is the way it is and will always be. Yet she must have asked herself, can the health service survive if there is no alternative future, how many other midwives will leave? A vicious circle is set up. The practitioner-assessor responds to constant interruption by buying care time at the expense of time she might have used to observe the assessee's practice and in particular aspects of practice which require her to make decisions about 'going with' or challenging the current situation. The assessee's competence to practise in ways that might improve this situation is never examined. The assessee is prepared to practise in the same predominantly responsive way as her hard-pressed assessor. The situation remains unchanged; practice continues to be done in a way that potentially jeopardises safety.

What alternatives might there have been? There is little doubt that this team is under pressure through lack of resources (two have left for an allegedly less pressure-driven role; no-one gets their lunch-break on time). It is no good asking them to work harder, they are working flat out. Better management might help, but given the staffing resource there will always be an element of 'playing it by ear'. It is perhaps not possible to find a short-term solution in a context like this. It would be possible, however, for assessor and assessee to map the nature and structure of the problem as they have experienced it, paying particular attention to the options available in the current situation, the decisions made, the situational factors that affect those decisions,

and their implications for further practice. Of course, under the circumstances described, finding time to do the mapping would be difficult, but given the fact that the alternative is practice that will be ineffective for the future and potentially unsafe for now, trusts must decide whether to provide resources for the relatively small organisational change that would enable assessors to concentrate exclusively on assessment for regular, short periods. The other option is to continue to participate in the preparation of a future workforce that may be unfit for purpose, with all its contingent implications for litigation.

### 9.4.4 Assessment as preparation for 'now', critique of now and preparation – through dialogue – for 'future' competence

*'The practice nurse assessor is one of three nurses in this GP practice and the only one who works full time. She has post-registration students undertaking community nursing preparation, student nurses (adult branch) and newly-appointed practice nurses for their preceptorship period. She is also clinical supervisor for a practice nurse taking a post-registration module in asthma care. The student is spending the morning with the assessor, who will be dealing with routine appointments, most of which are not asthma-related and has suggested that the student might spend some time working on her theoretical assignment, using a vacant office. She would then be at hand should any patient be referred with problems which the assessor perceives as relevant in relation to her programme.*

*The first few patients are seen on schedule despite the fact that the practice nurse is interrupted several times by queries from the receptionist, who is new and evidently uncertain about the accepted procedure. Soon after, however, her management of the consultations is disrupted on three occasions when she is 'asked' to put pre-booked patients on hold (sometimes for half an hour or more) to see patients referred by the doctors. As the morning progresses, she also has to leave her appointment patients to operate a triage system, seeing patients arriving without an appointment and assessing their need for (a) an immediate medical examination by a GP, (b) an appointment at a later date, (c) or advice and treatment from her, without recourse to the GP. She maintains that she rarely opts for the latter option because the doctors have made it clear they like to see patients before a decision is made about appropriate management of the problem.*

*Throughout the morning the nurse's work is interrupted by telephone enquiries and doctors coming into her room to request assistance. Her student is present on several of these occasions and is clearly uncomfortable. Later, during a discussion with the researcher, she says she thinks 'the doctors' interruptions were unfair to the patients' and that the nurse should have been more assertive. The nurse says she is 'reluctant to be assertive nowadays' because on an earlier occasion when they had just joined a newly formed primary care group, she suggested that what she called 'issues of protocol' should be aired at the monthly practice meeting, the doctors 'went ballistic' and made it clear that all practice decisions were to be directed through them. One of the consequences of the doctors' control is that the practice nurse is not permitted to deviate from the practice routine to accommodate students' needs, even where the student is an experienced nurse with a specific clinical remit.*



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*The morning progresses and still no patients present with respiratory problems. For most of the time the student has continued with her written work, with the occasional break to join her assessor. In conversation with the researcher, she expresses dissatisfaction with this arrangement but says she understands the particular pressures under which the assessor is working. She talks about the gap between current teaching, which emphasises the value of complementary skills and this practice where the different professions 'remain poles apart'.*

*The afternoon promises greater relevance, as it is a nurse-led asthma clinic. This is targeted at a small group of patients recently diagnosed as having asthma and involves a brief talk which concentrates on lifestyle issues and health education followed by a practical demonstration of inhaler use. The assessor gives the talk herself; apparently the GPs insist on this, but uses her student to reinforce the message, particularly in respect of smoking and asthma and its avoidance in public environments. She uses her student to give one-to-one demonstration and teaching in the use of inhalers, supervising this with the first patient and ensuring that it is competently performed. Thereafter both nurses work independently with individuals, planning to compare their results after the conclusion of the session.*

*At one point the student is left to close the session when her assessor is called away to attend to a patient presenting with a recurrence of acute cystitis. Despite the patient's known history and repeated instances treated identically, the assessor is not allowed to prescribe the necessary medication. The patient, who is due to go on holiday next day, is told to return that evening to see one of the GPs who is 'here but unable to see you at present'. The patient is clearly distressed and has to be comforted.*

*Discussing the incident later with the student, the assessor claims that in instances like this her role is that of 'go between', which takes away her professional autonomy. She tells the researcher that practice nursing is becoming less rewarding, with the convenience of the hours the only thing that keeps her there. She fears she is conveying this message to her students, despite her best efforts.'* (Vignette 13)

This assessor, despite considerable difficulties within her practice context, manages to engage in a dialogue with the assessee about some aspects of the 'problem' of practice nursing. She expresses guilt at doing so, worried that she might convey too negative a message. Nevertheless, she helps the assessee to consider alternative situations to the one to which she is currently exposed. She could have opted to do the job, as defined by the doctors, without comment, but she makes a different choice. They explore her options, including the option of leaving.

The GPs have refused to acknowledge that there is a problem and it appears that the curriculum planners, desperate to find clinical practice allocations for their assessees, have underestimated (or ignored) the difficulties for an assessee in a 'split practice' like this one. The assessor has responded by helping the assessee to start identifying the structure of the problem. Her approach is born of frustration rather than a conscious strategy but it serves to focus the assessee on 'now' competence as necessary but not sufficient. Assessor and assessee engage in evidence-based dialogue about the need for nurses to find strategies that challenge the persistent assumption among some doctors that nurses remain their handmaidens, and that nursing agendas remain secondary to medical ones.



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Because, by doctors' edict, the assessor was unable to alter her schedule to meet her assessee's needs, she decides to call the assessee only when someone presents with a respiratory problem. This appears to have been motivated by a concern that the assessee should not be forced to waste time. She might have made a different choice. If the assessee had been with her throughout the morning she could have decided for herself what was relevant and what not. Given the importance the assessor attributes to looking at the constraints imposed by the context, it would have been possible for her to hold a conversation with the assessee about this, using shared evidence rather than opinion. Instead, the evidence is not directly and experientially grounded for the assessee; she has to rely on the assessor's opinion which may be different from her own. However dire a practice context might appear to be, its practices provide evidence of the attitudes, discourses and values which create the conditions and a large part of the 'problem' that practice must address.

Does this example suggest a need for doctors to receive training with respect to their role in the development and assessment of other professionals? Are there ways in which some of the doctors might contribute directly to the practice education programme to help break down some of the more resistant prejudices on both sides? How, for instance, would the presence of a more enlightened doctor have affected the discussion about practice nurse autonomy? Could recommended training periods for new practice nurses (this community trust recommends three months) be (a) better implemented and (b) augmented to include preparation of the practice as a whole for student assessment?

In the meantime, this assessor has not only been able to offer the assessee an opportunity for critical dialogue but has also (in the afternoon session where she *does* have autonomy) worked alongside her *and* given her the chance to work autonomously in circumstances where she can make evident – through her actions – what her situated understanding is.

### 9.4.5 Assessment as preparation for unsafe practice

*'The location is the paediatric ward of a district general hospital, which has 28 cot/beds in three main ward areas. There are also single cubicles for babies, very sick children or those requiring barrier nursing, and the usual ward offices, milk kitchen and play area. The ward uses a team approach to nursing.*

*The student nurse is undertaking a diploma and is halfway through the child branch programme. She is part of 'the blue team', which has responsibility today for eight children. The ward staff is seriously depleted through sickness and the blue team is reduced to two – the student and the RSCN staff nurse who is her assessor. Inevitably, they are working independently at the moment, each coping with the needs of specific children.*

*31/2 hours into the shift, the student and her assessor have had no contact. On two occasions the student has required advice or assistance, but her assessor was completely occupied administering chemotherapy to a very ill child in one of the side rooms.*

*The first of these situations involves a baby with bronchiolitis receiving antibiotic therapy, who had developed diarrhoea. The student is unsure whether to take a stool sample, and has to seek advice from a nurse in another team. Her next dilemma is not knowing how large a sample was required; in this instance she seeks the advice of an experienced health care assistant.*

*The second situation involves taking the temperature of a fretful toddler with whom she has been unable to use a conventional thermometer. She*

*needs to use a mechanical aid but the item with which she is familiar is in use elsewhere. She successfully locates another mechanaid (a dynamap) and now needs someone to show her how to use it. Her assessor is busy, so she finds another nurse who interrupts her work to quickly outline the procedure.*

*On her way back to take the toddler's temperature, the student is accosted by two sets of parents requiring information, a doctor requesting assistance, the siblings of another patient wanting directions to the hospital shop and the mother of a little girl who is vomiting. She assists the mother in attending to the little girl and is then called over to his bed by a boy with asthma. He is wondering why he only gets one of his capsules today when he had had two previously. The child is not cared for by the blue team, but all his team's nurses are busy, so the student goes to find out an answer to his query, resolving the matter when she finds the nurse who administered the drugs, who tells her that, although similar in appearance, this capsule is twice the strength of those given previously.*

*It is now almost two hours since the student had her instruction in the use of the dynamap and she eventually gets to the bedside of the fretful toddler with this equipment. Despite the cursory nature of her instruction, the time lapse and countless interruptions, the student is able to recall the procedure and records the child's temperature. It appears significantly raised, and again the student has to look outside her 'team' (i.e. the nurse with whom she is paired) for advice as to the appropriate nursing intervention.'* (Vignette 14)

This vignette provides a 'thick description' of a disturbing set of events. An unqualified pre-registration diploma assessee is left unsupervised for over five hours. Her supervisor/assessor is in the vicinity but plainly not in a position to provide adequate supervision or assessment.

The assessee, who cannot in *these* circumstances be reasonably described as an assessee, has the initiative to seek help from whoever is available (and even those who are not). She demonstrates competence in not undertaking any activity for which she feels unqualified but there is a sense that the pressure in the situation is so great that she might feel compelled to carry out a procedure despite knowing she is not competent. In any case, there is no-one to see her making these decisions so she is not assessed as having that competence.

The assessee undertakes a range of activities that require detailed knowledge of the procedure for using a particular piece of equipment, the dynamap, which she was cursorily shown two hours before. She is learning that nursing competence is learned through one-off demonstrations (see one, do one!). Whither the possibility of research-informed nursing, whither the possibility of an analytical professional stance that would prevent gross error and death through unreflective acceptance of a procedure, whither – on the vine – the hope of safe, flexible, proactive health care.

The assessee not only has no opportunity for preparation for alternatives, she has no chance to prepare for the present situation. Although staffing on this ward has been reduced by sickness and may not always be as dangerously low as at the time of the observation, it was nevertheless entirely unacceptable from a nursing point of view, let alone an assessment one, on the day it was visited. It was not an appropriate learning environment and the assessee was clearly discriminated against in her assessee/learner role. The money being given to her education was, on that day at least, wasted, except in that it was used to subsidise staff shortages with an unqualified pair of hands.

The vignette raises a number of questions. What are a trust's obligations with respect to maintaining an adequate learning environment for assessees (both pre- and post-registration)?



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Should minimum standards be set for valid, reliable, fair and trustworthy practice assessment, to which trusts are committed contractually? Could there be designated learning environments with slightly higher staffing levels to maximise learning opportunities? How might the assessment of practice contribute to the evaluation of practice environments? What processes need to be in place to bring about change where environments are found to be prejudicial to educational opportunity, or valid, reliable and fair assessment, or safe practice, or all three?

## 9.5 Vignettes as a focus for dialogue: a summary

These vignettes provide evidence of what is happening with respect to the assessment of nursing and midwifery practice. They are taken from primary and secondary health care contexts, they involve pre- and post-registration assessees, they represent practice assessment for diploma and degree programmes, full-length (three/four year) and short (three/six months) programmes, and both generalist and specialist courses. They are taken from both nursing and midwifery and from different regions of England. There are eight vignettes in this chapter and further six in other chapters. It would have been possible to have many more that revealed the same state of affairs.

The research team would wish to reiterate, the evidence in the vignettes is mediated. It is sometimes argued that the purpose of educational case study is to: '*probe deeply and to analyse intensively the multifarious phenomena that constitute the life cycle of the unit [i.e. the case] with a view to establishing generalisations about the wider population to which that unit belongs*' (Cohen and Manion, 1989: 125).

Simons has proposed that each case is a unique instance: '*[case study] is the study of the instance, the particular, the unique*' (Simons, 1980: 1), while Adelman et al. argue that it '*is about moving between the general and the particular*' (Adelman et al., 1980: 47).

The research team believe however that the insistence on 'an instance' and subsequent claims about naturalistic generalisation are misleading. It is more helpful to think of each case being an example of '*interpretation in context*', grounded in '*a full and thorough knowledge of the particular*' (Stake, 1980: 69). See also Stake (1995) for a more recent statement.

The setting down of what is observed always involves selection and interpretation, even by those who are trained to check the validity of their representation with others who were there or who have had similar experience (Johns, 1995). The process of unpacking a vignette also involves interpretation, and although these interpretations are triangulated with participants' interview comments, interview data from participants in similar situations elsewhere, observations elsewhere, and the interpretations of other researchers, they cannot be said to be objective. This is because there is no such thing as an objective interpretation. What each vignette provides is a worked account from careful field notes made in a way that maximises the reliability of a range of subjective accounts. It is an *inter-subjectively* constructed picture or story. This is the closest it is possible to come to 'truth' when documenting activities that involve people in context where both they and the context are naturally changing and developing in the course of actions and interactions. Similarly, what each unpacking provides is a perspective on what is represented. Although this attempts to identify the dilemmas, options and choices faced by each individual in the situation, we can never be certain that we have identified them all, nor selected the ones of greatest significance to all the people there. We have tried, by discussing in subsequent interviews and targeting later observations, to verify that what we have pointed to as the key discourses and values at issue, are the ones that others have found from their own experience. But, in exactly the same way as with assessment itself, it is never possible to say that 'how I see it' is exactly the same as 'how you see it', only that 'we have made explicit to each other what we see, taken account of other perspectives in what we have recorded, and provided the basis for continuing dialogue about:

- available options
- values involved in making choices
- pragmatic agendas
- ethical agendas
- contextual constraints
- dilemmas
- action
- the iterative nature of unchallenged practice
- situated understanding
- practical theory
- validity
- reliability
- safety
- the short- and long-term quality of care
- implications for assessment.'

We would wish readers use them in a similar way.

## 10.1 Introduction

The story emerging from this evaluation is of individual practitioners dedicated to the provision of quality care, who through sheer commitment overcome the most difficult of operational circumstances. The story records the enormous amount of individual and collective work that goes into operating a health service expected to deliver more than it is (or, perhaps, can be) resourced to provide. It documents the daily challenge faced by practitioners as they attempt to provide individually-tailored care within a complex and unpredictable health care context, and highlights the work done at every level of nursing and midwifery and at every point in the caring process to meet individual needs within the constraints of the system. It is a story of unstinting physical and emotional labour.

## 10.2 A system founded on individual effort

The previous chapters offer an account of the dilemma nurses and midwives face in trying to maintain professional standards while having to make pragmatic compromises. It reveals how difficult it is to avoid compromise in the context of 'getting the job done' and how compromise is often inevitable and always problematic, and points to the thin line between what is acceptable and what is not. Effectively, it shows that carers' judgements are value-based as well as knowledge-based. Practices which cut (procedural) corners or play the system in response to limited resources are revealed as the enactment of judgements about what would constitute the least serious compromise.

The story is about individuals struggling to survive *and* provide effective care within a health care system that is so complex that it will always challenge their efforts. In that sense, the story is about an interaction between individuals, sometimes organised as groups or teams, and the health care system. But it is also the story of the system itself, its organisational strategies and structures, its operational and bureaucratic agendas. What emerges is that organisation and structure at local and whole-institution levels often exacerbate the already difficult work that is nursing and midwifery.

This report tells the story of a health care service made to work at considerable cost to nurses' and midwives' physical, emotional and mental wellbeing. It records how an increasing number of carers feel the constraints they work in as a threat to their sense of professional worth. In short, it reveals why dedicated people doing their best in the circumstances are obliged to put 'getting through the day' as high up the agenda as giving care.

It is into this scenario that assessment is inserted. Under the circumstances it is not surprising that many practitioners experience assessment as an additional burden.

## 10.3 Creating structures for *monitoring* assessment

Assessment takes time. If an assessor does it conscientiously, assessment (as currently executed) is likely to take their attention away from the task of giving care. It often seems to be about what academics believe is important rather than what the practitioners know from experience matters. Work is often organised in ways that make it difficult for people to stay in stable teams for sustained periods. This in turn decreases continuity of contact between assessors and assessees. Where there are pre-registration students in a clinical environment they are often only present for short periods (sometimes less than three weeks); this seriously restricts opportunity for communication and critical reflection. To overcome such systemic difficulties assessors must double their energies, giving personal time to meet with their assessee *after* client needs have been attended to.

But even if they give their personal time to work with their assessees, assessors often cannot find time or space to do assessment in ways that reliably and validly capture the quality of situated action and practical theory. In any case, assessment that takes place outside the context of practice more often than inside it, is not only bound to be perceived as additional work but also likely to prove inadequate as a way of finding out about an assessee's competence. There are, however, a number of bureaucratic structures to minimise the worst effects of this set of factors on assessment validity and reliability, including:

- visits by education tutors to clinical environments to support practitioner-assessors in the workplace
- placement liaison officer co-ordination activities
- pre-validation meetings
- paper and electronic communication of assessment information.

The world of practice, including the world of assessment practice, is never singular, of course. These structures work more or less effectively according to who holds a given role and/or the pragmatic and political constraints on the feedback of useful critical advice. In any event, our observations suggest they are most effective where additional monitoring and liaison are carried out informally through personal networks and cross-institutional meetings. These help to support and develop communication and dialogue as an integral part of practice itself. Contexts where these conditions exist offer supportive learning environments and, therefore, conditions under which assessment can be carried out as a practice-integral activity. As well as being supportive to learning and assessment, the contexts described are ones where learning and assessment are regularly monitored. This occurs because there is a set of networks for exchanging information about the nature and quality of the assessment activity and a number of 'live' nodal points in the network. The most commonly identified were:

- practitioner-assessor support forums convened by an educator
- communication networks created by committed individuals
- situated development work by people with higher education qualifications.

As is made clear below, only a small number of these frameworks, networks and roles are part of a planned, institutionalised set of procedures. Section 10.4, therefore, describes a nascent structure without a supportive infrastructure. Few of the places visited provided time or material to facilitate the systematic monitoring of assessment; the knowledge and trust generated by informal monitoring is a valuable first step, but must be costed against the time and effort invested by individuals unsupported by a larger infrastructure. The structures described created a starting point for systematic monitoring but in the meantime only provided a patchy and *ad hoc* perspective. To be effective in a way that would give the public confidence that new practitioners are being adequately assessed in the context in which they will work, and experienced practitioners are being supported to practise in a changing world, there needs to be an institutionalised infrastructure for monitoring assessment. The roles, structures and resources that would make such an infrastructure possible are described in Section 10.6.

## 10.4 Unsystematic formal monitoring structures

### 10.4.1 Educator-tutor visits to practice environments

The research team visited and observed many educational institutions where educators were making a determined effort to support practitioner-assessors by maintaining regular contact, despite the fact that visits often involved travelling many miles or spending long periods in congested traffic, making them costly in terms of educator-assessors time. (These visits did not always bring contact with assessees, many of whom complained that they were never or rarely seen while actually doing their clinical work.) In the majority of institutions, every member of

a programme team could in theory be contacted by telephone to deal rapidly with general queries from practitioner-assessors; most also went into clinical areas for face-to-face contact. When such contact was regular it served a useful monitoring function with respect to serious problems. However, because many tutors spent most time in clinical areas with which they felt most in tune, monitoring was uneven with visits to least favoured areas focusing on reactive troubleshooting and localised contact maintenance.

### 10.4.2 Placement liaison officers

Most educational institutions had an identified placement liaison officer whose role was to ensure that there were sufficient clinical environments to take pre-registration students, and to co-ordinate post-registration supervision. Although this person was sometimes also responsible for educational audit of clinical areas, their role was primarily bureaucratic. Their time was largely used in keeping up-to-date lists of contacts and outline descriptions of previous student placements, which left little time for initiatives. Also, any pretension they might have had to use the information from audit to be more selective about placements was thwarted by the need for placements of some sort.

Under such circumstances it would have been surprising if liaison officers had given much attention to gathering information on the quality of assessment in specific placements. As was the case with the education tutor, this was largely a systems-maintenance role to serve bureaucratic ends before educational ones. Assessment monitoring was potentially possible but only in one case was it in the frame.

### 10.4.3 Validation pre-meetings

Usually, when validation was being sought for a programme, ordinary members of the educational institution and trust would meet with executives to agree a set of processes and procedures for assessing practice. Officers from trust(s) would meet their educational counterparts to agree a strategy for dealing with assessment during the validation proper. A representative small group of potential practitioner-assessors would sometimes meet with university assessment officers to discuss the finer points of assessment on award-bearing programmes. The researchers were aware of at least one team who brought in outside advisers to help devise a practice assessment schedule.

The research team followed a number of validations through pre-event, event, and post-event meetings. By the time a validation event occurred, programme teams were usually able to report that a high level of consultation about assessment had taken place. Our observations confirm that these consultations were treated seriously and that assessment sub-groups (usually comprised of lecturers and practitioners) spent considerable time preparing assessment schedules and procedures.

The research team were unable to discover any allocation of resources by trusts to facilitate the subsequent institutionalisation of these procedures in clinical environments, or to monitor their effectiveness. Put bluntly, some trust officers made commitments at validation events that were not honoured if they involved the allocation of additional resource. Senior trust officers expressed a desire to be involved in the design of local nursing/midwifery curricula but seemed to assume, almost without exception, it was the responsibility of the educational institution to create and resource the necessary structures for assessment. Potentially, however, the collaborative structures set in place through validation have the capacity to facilitate a mutually advantageous assessment monitoring process.

### 10.4.4 Paper and electronic communication

As indicated in 10.4.1, attempts to institute *proactive* liaison were most successful where clinical practice environments were located relatively close to educational institutions. Most institutions worked in partnership with trusts across several sites, with which effective

liaison was almost entirely through site visits. Despite the resource of electronic information networks in both the institutions and trusts, few situations where the link was used for educational or assessment purposes were identified. In the few where there was a link, the use of e-mail for dialogue was heavily outweighed by its use to transfer information about, for example, regulations, programmes on offer, and study packs available. Telephone use excluded, the main potential of electronic communication for monitoring assessment is yet to be realised. At present, electronic media are used as a sophisticated form of paper on which single-authored texts are transmitted to a set of readers.

## 10.5 Some effective informal monitoring structures

### 10.5.1 Practitioner-assessor support forums

Most educational institutions arrange a small number of meetings annually to discuss assessment issues with practitioner assessors. Those who attend these meetings find them useful as a forum for expressing their anxieties. The most commonly mentioned are listed below:

- The need for clarification about the wording of criteria in assessment documents.

  *'The document is unnecessarily complicated.'*

  *'You have to enlist the students' help to interpret it intelligibly.'*

  *'The documents are in jargon. They should be user-friendly. As it is, we [assessors] have to go to the students to get their help in working out what they actually mean by 'suitable' learning objectives.'*

- The need to clarify the different expectations for diploma, degree and post-graduate assessees.

  *'Sometimes you wonder just what is meant by the different levels and grades we are supposed to have in mind. I mean, I can see it in writing their essays or whatever – but you can't always apply it to what you do in practice.'*

  *'I find it all a bit nebulous – like I'm making a judgement here about how their skills develop and what are the differences for students and post-reg. But in reality, you get good and bad at both levels. It probably depends on the exposure they've had to that particular problem before.'*

- The need to know whether there were agreed indicators that demonstrated different levels of practice.

  *'The documentation from the university does not easily translate to the practical experience. To my mind, we should not be talking about – even concerned about diploma students failing to gain clinical expertise at a specified level. It's an entirely different range of expertise. You can't measure it the same way. These nurses are not less skilled. They have a greatly enhanced range of skills.'*

  *'I find huge confusion with so many pre- and post-reg. courses on offer – all of them seem to need something a bit different out of a clinical placement here. While I can see the logic of that I wonder – but it's probably very naive on my part – why there can't be one assessment form and a lot fewer levels – just a basic difference for conversion courses, students and the post-reg. Is there any chance that the school could make it simpler, do you think?'*

Indeed, practitioner-assessors reported feeling that meetings were worthwhile because afterwards they *'knew now what the other people were getting at'*. This was despite the fact several

initiatives were observed where the agenda was the property primarily of the co-ordinating lecturer, who was the only person to attend every meeting. What practitioners reported finding of particular value was the fact that meetings offered a means of establishing and maintaining trust between themselves and programme co-ordinators.

During fieldwork observations the researchers witnessed considerable effort put into arranging regular meetings, and had the outcome in terms of increased mutual trust reported. However, because most meetings were arranged on an *ad hoc*, voluntary basis and took place away from the clinical environment (in an educational institution) they were often poorly attended by practitioners, who felt unable to leave the clinical area or were unable to make themselves available because of their shift pattern. While a few groups maintained continuity of contact, it was not uncommon for a three- or four-meeting series to be attended by different people each time with as few as one or two of the same practice staff present at all of them.

A further consequence of the voluntary and *ad hoc* nature of many of the meetings was that each revisited topics previously discussed at length, resulting in little progress to new understanding of the processes of assessment as a practice in itself. None of the meetings explicitly considered the factors that would affect the *reliability* of individual assessor's judgements, what would constitute *valid* evidence of competence, or whether there was *inter-assessor reliability*. It was taken for granted that assessment meant working with pre-specified criteria on the assessment schedule. The potential exists, however, for the meetings to consider factors that might affect the reliability of assessment, such as assessor expectations and the learning/assessment context.

Meetings did make a positive contribution to assessment in preparing the ground for the development of trust between educator-assessors and practice-assessors and providing the opportunity for dialogue between practitioners. Through discussion, practitioner assessors began to come to a better understanding of the difficulty of formulating practice assessment criteria, as well as – to some extent – reaching a degree of agreement about their meaning. Over and over, the criteria were made explicit in relation to concrete contexts. What was a hard and fast rule for competence in (say) an ITU was only occasionally the case for (say) community mental health nursing. Educators were reminded of practitioners' unease with what the practitioners called educational jargon and were often prompted to translate criteria. From the dialogue in these meetings, several practitioner-assessors arranged to develop criteria for their own clinical context, in collaboration with their educator-assessor colleagues.

As arenas for boosting mutual understanding and increasing individual confidence, then, these meetings served a useful purpose. Trust provides the bedrock for dialogue which in turn enables the trustworthiness of the assessment process to be considered within a non-punitive agenda. The meetings are a useful way of providing the conditions for this to happen if there is sufficient continuity. The research indicates that they would be even more valuable if they worked with concrete examples of practice that were demonstrably relevant to a particular working environment. We would deduce from this that at least some of these meetings need to be workplace-based.

### 10.5.2 Networks created and maintained by committed individuals

In a small number of institutions visited the researchers met individuals who, despite the ineffectiveness of the official liaison system, had a comprehensive understanding of what was happening in the clinical practice environments where assessees were placed. They were committed individuals who gave their own, non-allocated time to visit clinical sites to maintain goodwill. Although those observed and interviewed were programme co-ordinators and a co-ordinator of assessment policy, others with these roles did not achieve the same outcomes. It seemed clear that it was the individual that mattered rather more than the role, although if they held an official assessment co-ordination or monitoring role that no doubt strengthened its effectiveness.

When these individuals were interviewed and observed at work, the researchers quickly noticed their extensive first-hand knowledge of what particular clinical areas had to offer and who could be relied upon to be sympathetic to assessees' needs. They often visited clinical areas and were perceived as *'knowing what the job is about'* by the people there. In two of the cases studied, this personal link was absolutely crucial in carrying educational institution/trust relationships through a difficult period when members of the trust bureaucracy lost confidence in the partnership and were contemplating withdrawal. In both instances, key members of the trusts cited confidence in a named co-ordinator as the factor that persuaded them to maintain a working relationship with an institution when breakdown at system level was imminent. The commitment, hard work and professional dedication of trusted individuals acted as a counterweight to failings at a system level.

However, because the individual was making good the failures of the system in time that they would otherwise have used for these other educational commitments, they were often left tired and unable to meet these. The most common casualties were:

- research for personal/professional development
- the production of research papers for the research assessment exercise (RAE).

> *'We have to be clinically aware and clinically visible – but the reality is, that it is a struggle. You don't always feel credible. You don't have time to really update your practice – but you try to fulfil all those expectations – at least to be a sound educational resource person for them … but what gives is you. Your working life suffers. Your personal life suffers. You are under an enormous amount of stress.*
>
> *We are supposed to write for publication - but when do you ever have time to do that?'* (Programme co-ordinator)
>
> *'We are all doing courses – Masters and the like. We have to have a specialist subject area now you see … so there's a college day for that if you can get it in.'* (Programme co-ordinator)
>
> *'Some weeks I don't get to my area at all. There's always a heavy teaching workload. So you teach. You do all your lesson prep … meetings of the course management team … student interviews and recruitment – we all get pulled into that – pre-selection interviews, informal interviews – loads of marking – we have such big groups now. And if you do any post reg., the courses run back to back.*
>
> *So there's not much slack in the system. I certainly don't plan on being able to keep up with any reading or do anything about writing papers during working time.'* (Lecturer)
>
> *'When we went into the university it was on "other related pay". None of the teachers from the school of nursing went in on the academic scale. Well I've always been very clear what I wanted from the integration, so I was among the first of those who applied to do this – go on the academic scale. And there's a probationary period and you have these criteria to fulfil. You know, develop a research profile – publish six articles a year in refereed journals.*
>
> *Well it's virtually impossible working here. The demands have never really altered to take account of this. I still do just as much teaching and then there is one day a week I am supposed to be in my link area. I had high hopes initially of utilising that in some way … you know, developing the contacts and perhaps doing some collaborative research. But in reality, I'm too busy to do it and they're too busy to think about it. It was easier*

*years ago when I first worked as a teacher. You could forge those links and if you were so minded, you could do joint work with them.*

*It's so difficult now. I'm thinking of asking to revert to "other related". At least it would take the pressure off.'* (Lecturer)

### 10.5.3 'Qualified friends'

The researchers spoke to a small number of educational consortia members with a higher education qualification whose comments made it clear that they devoted considerable energy to trying to direct attention to educational issues. It was not possible to observe any consortium in action, but interviewees reported that most members were driven by an agenda focused primarily on ensuring their trusts had sufficient establishment. The main concern of a consortium, if and when it considered assessment, was whether or not the educational institution would deliver enough qualified staff to fill posts at specified grades or within given clinical specialisms.

*'You've got to play it carefully 'cos all the different trusts have their own agendas and the bottom line is they've got to get enough new nurses to do the specialties they need, but I'm beginning to get them to see that they need to have people who think.'* (Consortium chair)

It would have been difficult for anyone to make headway with an educational agenda that did not satisfy this economic agenda. There are obvious conflicts between the economic and educational discourses. Where progress was anticipated this was because the 'friend' of education was not only educated but also strategically sophisticated. They used their understanding of educational issues to encourage members of consortia to consider the longer-term need for a body of practitioners able to think for themselves and make independent judgements. The research was not in progress long enough to establish whether the favourable responses to these aims were implemented, although there was little immediate evidence of progress. The qualified consortium member caused others to reflect from time to time on the purpose of practice, education for practice and assessment of practice. By doing so, they initiated an early stage in the monitoring process at an institutional level.

## 10.6 From piecemeal *quasi* structure to integrated infrastructure

### 10.6.1 Networks and dialogue nodes as an infrastructure for trust

The research evidence shows that currently the main means of supporting practitioner-assessors in their work with assessees is through pockets of activity initiated by individuals. These activities take the form of liaison meetings located away from the practice environment or of visits to clinical arenas. Both are carried out in a piecemeal way, even when planned to be more structured, and are constrained by pragmatic and practical agendas that may conflict with the individual's or institution's educational aims. More systemic centres of activity, such as validation events and education consortia meetings, similarly prioritise the pragmatic, political and practical and resist promotion of the educational. For the most part, these individual and piecemeal activities act as a substitute for a comprehensive structure to assure the quality of assessment.

The development of this stage (Stage 1) can be represented as follows:

**Stage 1**

Individual networking:

- programme tutors available for troubleshooting
- committed individuals willing to ensure strong, across-the-board liaison

- placement co-ordinators
- educational 'friends'.

Creation of potential dialogue points:

- educational institution organised discussions about practical issues of doing assessment
- validation pre-meetings
- 'specific location' practice site visits by a full education programme team.

Stage 1 structures alone do not provide an adequate infrastructure for assessment of practice in the practice environment, but they do lay the foundations for it. Although many of the elements are at worst minimal devices for keeping the show on the road and ensuring its smooth running, meeting organisational objectives not educational ones, at best they construct the conditions for trust and dialogue through which educative assessment can be developed. Appropriately supported, networkers and communication points can help develop reliability, validity and fairness. They can also become focal points for discussion about the relationship between learning, assessment and practice. They are already essential existing components for change and as part of a broader, better-institutionalised structure they can become primary agents of transformation.

### 10.6.2 Collaborative structures for education, curriculum development and assessment of practice in practice

The research has identified a number of additional structures and processes to support educative assessment. What marks these out is the fact that they are institutionalised, implemented on a wide scale and the responsibility of many rather than a few individuals. They combine to create conditions for progress beyond mere maintenance of the system to development of assessment as a means of assuring and improving the quality of care. The second stage in the process of developing an assessment infrastructure is represented below.

**Stage 2**

Organisational structures for collaborative monitoring:

- combined educational institution/trust strategic planning teams
- joint validation panels.

Educational structures for continuing education for practice assessment:

- trust and educational institution jointly constructed programmes leading to an academic qualification that recognises the centrality of practice
- lecturer-practitioner joint appointments

Curriculum/assessment partnership structures:

- joint curriculum planning committees
- joint decision-making bodies
- joint research programmes.

The research evidence strongly suggests Stage 1 and Stage 2 structures need to be supported by a large number of practitioners whose role includes a substantial focus on assessment and a smaller number who focus almost exclusively on the co-ordination and monitoring of practice assessment. These roles would be properly remunerated from joint educational institution/trust funds. In the more successful of such roles which currently exist (lecturer-practitioners, in particular) the role holder is not only able to assess close to practice but also to help create congruence of individual and institutional approaches to learning and assessment in practice. There may also be a case for a new role for a practice assessment quality assurer (possibly educationally-funded).

## 10.7 Towards a fully fledged assessment monitoring structure

The research has shown that quality assessment requires training to enable assessors to:

- develop their skills of *in situ* evidence collection
- recognise situated understanding in assessees' actions
- promote *in situ* discussion about situated understanding and action
- develop analytical and critical skills.

The research also indicates the need for an infrastructure to support assessors in the clinical environment as they develop these skills. It shows that the current structures reinforce practitioners' tendency to treat theory and practice as separate entities and assessment as a bolt-on official duty that intrudes into their 'proper' business.

A description of the third stage in developing an assessment infrastructure has been compiled by combining various elements identified in a range of institutions and projecting forward from these to the 'ideal' structure. Never were all of these found together in one place, nor did their presence lead to standardised assessor behaviour. The researchers believe it would be a mistake to look for either feature. A developed structure serves its most important functions in supporting individuals as they struggle to understand puzzling aspects of assessment and helping them see the need for peer review. It discourages a deficit view of difference and variation in assessor perception, founded on the false notion of objective assessment, and encourages dialogue that brings different subjective assessments together to form a more valid, reliable and fair assessment.

**Stage 3**

Development structures:

- training for all practitioner-assessors
- regular updating for all practitioner-assessors
- training for advanced practitioner-assessors
- advanced assessment qualification with focus on:
  - research as a process
  - practice as a set of *in situ*
  - principles of assessment
- opportunities for practitioner-assessors to carry out case studies of practice assessment in places other than their own.

Monitoring structures:

- regular light sampling (at clinical area level) of inter-assessor reliability within the team serving a single clinical environment
- regular light sampling (at trust level) to establish comparability of clinical contexts within the trust
- regular fora for dialogue (at regional level) about initiatives and issues in the assessment of practice
- establishment of advanced assessor role to carry out co-ordination of peer reviews and clinical context audit
- regular reviews of the range and scope of evidence treated as proof of practice competence.

Stage 3 builds a meta-structure for monitoring the assessment system itself and provides a framework for developing awareness of practice as a genuinely and actively research-based activity. It is grounded in experience of assessment, like patient care, as a set of practices to be worked out in the doing. Importantly, it facilitates dialogue about difference, as a way of moving towards comparability in assessment practice without diverting attention from caring.

This monitoring meta-structure sets out to avoid the pitfall of treating assessment as an ideal activity that can be regulated into perfection through the construction of an (impossible) context-independent set of assessment documents and devices. At the same time, it attempts to build in processes for increasing validity, reliability and trustworthiness through dialogue. It assumes adequate resourcing because it is grounded in evidence that without an adequate monitoring infrastructure, practice assessment is often unsafe.

## 10.8 Conclusion

Assessment quality assurance practice and deployment of resources varies greatly across the country. Although there are currently no designated training environments for assessors, there *are* environments with the characteristics outlined above, where practitioners work together as often as possible, pooling knowledge and sharing understanding about patient needs and possible care. Typical among such environments are those provided by nursing research and development units and several types of team-based nursing units. They are places where handover involves educational dialogue and problems are the focus for exploring a range of alternatives. These, and other less well conceptualised units, offer environments where opportunity for gaining 'natural' access to situated understanding and practical theory is high. They are, in brief, places where practice, education and assessment are integrated for much of the time because:

- nursing or midwifery is organised on a team basis
- contact between assessor and assessee is continuous over a lengthy period
- private understanding is regularly placed in the public domain
- differences are regularly shared through discussion
- there are regular meetings to discuss 'difficult' cases and inform action
- uncertainty is welcomed
- alternatives are explored
- there is a recognition that practice and assessment both involve similar processes
- research into practice is high up the corporate agenda and actively pursued whenever possible.

Such environments are spread unevenly, however, creating a built-in unfairness in learning and assessment.

Many assessees only sporadically and serendipitously encounter environments where assessment is inextricably interwoven with a *learning* environment. While it may be a matter of dispute that every clinical environment is capable of fully incorporating these features, there *is* a case for strengthening existing mechanisms for monitoring clinical environments as learning/assessment environments. The aim would be to ensure that learners encounter at least one such environment and experience the best quality learning/assessment environments more often than not.

Effective monitoring requires the formalisation of a monitoring process currently carried out informally by most educational institutions. It would examine the validity, reliability, trustworthiness and fairness of an assessment system as it is actually practised. The process would involve monitoring:

- clinical environments for active implementation of learning/assessment strategies (not 'opportunities', as at present)
- the range and scope of learning/assessment structures actually used
- clinical teams for evidence of appropriate qualifications in the assessment of situated understanding
- action taken to improve collaboration with designated clinical learning environments that meet monitoring requirements
- action taken to restrict use of clinical placement areas that do not meet monitoring requirements.

Projecting forward from the fieldwork evidence, it is possible to suggest further features that might be built in to practice environments to strengthen the integration of education and caring, thereby increasing the probability that assessment will be valid, reliable and fair. These environments would encourage and facilitate:

- access to the Internet via computers in the workplace
- access to a range of health care information databases
- use of a variety of types of evidence (e.g. photos, patient's accounts, colleagues' accounts, medical and nursing notes)
- processes for the construction, storage and retrieval of home-grown data
- processes for the construction, storage and retrieval of home-grown case studies and vignettes
- regular team meetings to review both Internet and home-grown data
- occasional meetings to evaluate responses to particular contexts and consider possible alternative for slightly different contexts.

Learning and assessment environments would be deliberately structured, then, to generate the construction of a body of tangible experiential evidence. This would be used by the care team as a practice resource but could also be drawn on by individuals in the team to make a case for changing either the practice or its context. The primary purpose would be to improve patient care but the quality of assessment would be improved too.

Strategic and tactical implications can be drawn from this research. The overarching strategic implication is that to achieve high-quality education in clinical practice, the design of practice curricula and assessment strategies should be seen as a whole, forged from the materials of the practice experience itself. This strategic orientation is articulated by the following specific strategies, together with indications of appropriate strategies for achieving them.

1. **Valid assessment will focus on the reality of practice as experienced by practitioners, not on idealised versions.**

The research evidence shows clearly that nursing and midwifery is done as survival for much of the time. It also indicates that practitioners have to choose between courses of action, including judgements about what activity to prioritise, in circumstances when everything is wanted immediately. They work pragmatically as much as from theoretical principles generated outside the context of action, attending to what works in given situations and when to take a less optimal course of action in order to facilitate another. Practice is often untidy, with unresolved issues; practitioners are unable to solve every problem they encounter. The best they can manage on many occasions is to 'map' the problem and learn from it.

- Assessment should involve close observation of lived experience in authentic practice contexts and evaluate the assessee's competence in dealing with dilemmas faced.
- Assessment should involve the analysis of evidence of situated decision-making and action, with a focus on identifying, discussing and evaluating criteria for judgement.
- Assessees should be enabled to work with accounts of practice that tell it like it is and thereby map real practice problems with richly described contextual details.
- Assessment processes should be grounded in the core research activities of evidence collection, analysis, action and evaluation.

2. **Reliable assessment will take account of the reality of *doing assessment* in the context of a clinical environment but will be structured to ameliorate the worst effects.**

Practitioner-assessors constantly experience role strain, and consequently they often spend little (or, in a few cases, no) time with their assessee. As they work they are constantly distracted from the current activity by the need to answer the phone, deal with a query, provide information to another professional, or attend to a patient crisis. Assessment is actually done most often informally by the people the assessee meets and works with by chance. Few assessors are with an assessee for any length of time. Formal assessment, when it does occur, is focused on learning contracts, assessment schedules or assignments, and can take up to two hours.

- Assessment should, wherever possible, be team-based to minimise the problems of *ad hoc*, intermittent and serendipitous evidence collection that occur when assessment is done officially by a preoccupied individual and unofficially by a diverse group of casual contacts.
- Assessment should include discussion that occurs as a part of the working day, with evidence and issues contributed, where possible, by all members of a team, including the assessee; the decision about whether this occasion should be a handover, a case conference or some other event should be taken by the team itself.
- Assessors should be freed systematically from the constant pressure of giving care to enable them to focus on the assessee (see below).

3. **Valid/reliable assessment of practice requires effective structures to support observation and dialogue in the workplace.**

The research indicates that where an assessor is able to work with an assessee for a sustained period they are able to observe what is done in relation to the possibilities of the situation, and discuss it with the assessee in the course of the doing. It also indicates that many assessors are only able to directly observe assessees' practice in short, intermittent and *ad hoc* stretches when there is insufficient time for reliable evidence collection. This, in turn, considerably reduces the validity of any subsequent dialogue and, therefore, of the assessment itself.

- Clinical practice should be organised to enable assessors to work alongside assessees in the clinical environment for set periods, free from normal clinical obligations.
- There should be a minimum time prioritised for assessment-only activity involving observation alongside the assessee as part of a specified minimum overall student entitlement, with the decision about whether this should be, for example, one hour in every 12 or a full shift once a week, being a matter for negotiation between educational institutions, nursing/midwifery professional bodies and trusts.
- Periods of allocation to a placement should be sufficiently long (preferably eight weeks or more) to enable continuity of assessor/assessee contact.
- The identification, collection and analysis of evidence (elements of truly research-based practice) should become integral practice activities to obviate the need for 'bolt-on' assessment procedures.

4. **Fair and comparable assessment requires documentation of constraints and possibilities in individual clinical environments and variations in quality between contexts to be taken into account in evaluating an assessee's actions and explanations.**

The research evidence shows that clinical environments vary considerably in the opportunities they offer for learning. Some have teaching materials and electronic databases, many do not; some secondary care teams utilise handover times for discussion of issues in addition to patient conditions and care plans, others do not; a number work on a team basis and share perceptions and concerns, many do not; most community care contexts offer one-to-one student/assessor contact but no opportunity for a second or third perspective; some GP practices continue to be dominated by a medical rather than a nursing agenda. There are a large number of clinical environments where the level of staffing is such that all available time is given to coping with the demands of patient care, and a small number where resources and practice organisation have been used in ways that enable assessors to spend time working closely with their assessee. Some clinical environments have enough low-pressure times to permit adequate assessment, while in others the care pressure peaks regularly outnumber the troughs.

- There should be joint assessor/assessee analysis of the constraints and possibilities of the practice context, based on observed and agreed evidence.
- Assessees should be observed in a range of situations, from those demanding a usual response, through those where there is a real possibility of exercising choice to deal with the immediate situation, to those where there is a need for strategic action to bring about change in the context of care.
- There should be training to enable assessors to recognise judgement/decision-making in assessees' practice and to take the lead in initiating dialogue about these in relation to dilemmas created by the working context.
- Best practice will take place in special learning environments, where staffing levels and learning-support structures and materials meet an approved standard, with the possibility that the criteria might vary according to the nature of the nursing/midwifery activity.



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- **Best practice will take place where trusts expect to accept responsibility for providing appropriate learning and assessment environments within agreed criteria.**

5. **Assessment must identify and evaluate assessees' situated understanding and practical theory in a full range of contexts.**

Observation in clinical environments reveals that circumstances often oblige supervisors and assessors to focus on whether a student has the skill to do a particular procedure, and whether their knowledge is sufficient or deficient for activities they engage in. Because there is an imperative to act immediately without causing harm, assessment is often about the extent of an assessee's exposure to hitherto unfamiliar knowledge and skill and their ability to incorporate just-learned skills and knowledge to do an immediate set of tasks. The research also shows that other forms of knowledge influence assessors' decisions about level of competence but are usually taken into account at a subconscious or intuitive level. An assessee's ability to sense something wrong through their fingertips and to utilise pragmatic knowledge to prioritise competing demands shape assessors' judgements but are only occasionally addressed explicitly. Most discussions about theory take place away from the workplace, with education-assessors, and are consequently no longer located in verifiable, recent evidence.

- There should be training for assessors to become competent in collecting evidence of applied 'subject' and/or research-based knowledge by observing and documenting how assessees enact the knowledge in practice.
- There should be training for assessors to become competent in identifying fingertip knowledge and pragmatic knowledge in an assessee's practice.
- There should be training for assessors to become competent at initiating analytical dialogue about what an assessee knows, understands and does, and structures for making this possible within or close to the practice environment.
- Training should, wherever possible, involve several members of the same clinical team to facilitate processes of systematic, collaborative collection of situated understanding and action across a full range of contexts, and to provide the conditions for dialogue.
- Training should include the study and making of vignettes of actual practice constructed around actual experiences and written down soon after those experiences as a focus for assessor/assessee dialogue in the workplace.
- Evidence from an assessee's portfolio, selected by the assessee, should be the focus of discussions about practices and values in their particular clinical environment.

6. **Effective assessment will dispense with current notions of levels of practice competence and differentiate between competence for 'now', an 'alternative now' and a different 'future' in terms of parallel processes.**

The majority of research informants claimed not to be able to detect levels in practice; a competent practitioner was a competent practitioner. Some assessment schemes attempted to assess practice competence using criteria such as critical awareness or coherent explanation, borrowed from academic grading systems. Others used a novice-to-expert scale, with increasing autonomy as the guide criterion. Observation of what experienced practitioners do, however, indicates that they broaden their scope of competence, but continually move back and forth between a small number of parallel processes, as they cope with the situation as best they can in the circumstances, choose to do something different within those circumstances or challenge the situation and take strategic action to change the context.

- Development in practice competence will be assessed in terms of a broadening of perspective to encompass different types of parallel process for practice for 'now', an 'alternative now', and the 'future'.

- **Artificial notions of level, which create disjunctions between types of practice, will be dispensed with.**
- Curriculum and assessment should be designed to facilitate students' ability to construct rationales for explanation and understanding at both tactical and strategic levels of action.
- Training for assessment should prepare assessors to help students construct rationales for explanation and understanding at strategic and tactical levels of action.

7. **Valid and reliable assessment can only be achieved when assessors are supported by an infrastructure of training and continuing support which acknowledges the inter-subjective nature of assessment and provides opportunity for dialogue to build on and enhance the professional judgement on which this is based.**

There was clear evidence that, despite the best efforts of many educational institution/trust partnerships and a number of highly-committed individual co-ordinators, infrastructures for preparing, developing and supporting assessors were often less effective than was hoped. Few assessors felt well prepared for assessment and most found the job difficult to do within practice because of the many other roles they had to undertake at the same time. Assessors were often concerned about what was meant by the wording in documents and about understanding levels criteria. Most did not feel that assessment attended to the reality of the practice world. Off-site meetings were arranged in many institutions to bring assessors together to discuss the aims of assessment and explore any problems practitioners had faced. These meetings were often arranged at times when assessors could not attend because of practice or off-duty commitments, and characterised by lack of continuity/development from one meeting to another. The focus of attention for practitioners was usually on the pragmatics of doing assessment rather than on the principles.

**Training**

- Assessor training should develop assessors' ability to engage in evaluation and dialogue about the role of situated, practical knowledge in a range of real-life cases.
- Practitioner-assessor training should provide preparation for dialogue.
- Assessor training should look at issues of validity, reliability and consistency with full regard to the role of judgement and decision-making in the busy clinical workplace.
- Assessor training should provide assessors with the opportunity to collect evidence and analyse data from their own practice in their own specific practice environment.
- Assessor training should provide participants with the opportunity to work collaboratively with other practitioners to examine practice in context, drawing out and examining differences in perceptions, assumptions and values.
- Assessor training should include a focus on critical analysis of difference.

**Continuing support**

- There should be a significant increase in the number of practitioners holding joint assessment/clinical roles with systematically allocated time for:
  - developing practitioner-assessor dialogue
  - coordinating assessment in a given clinical environment
  - facilitating the placement of informal evidence into the public domain for discussion (e.g. through team meetings in the clinical workplace; a systematic programme of continuing education fora at inter-area meetings).
- The scale of the responsibility of this practice-located practitioner/assessor role should be recognised through appropriate training and remuneration.

8. **To be valid as an indicator of practice competence, awards for diploma, degree and post-graduate programmes with practice as a major focus will need to incorporate a practice level descriptor that recognises development in ways that are different from those in academic levels criteria.**

Interviews reveal that the majority of practitioners find it difficult to relate levels of practice to academic criteria, and it is clear from observation of practice that these criteria are not appropriate, even though some advanced academic skills such as analysis and critique are regularly employed by advanced practitioners. They are also employed, but in relation to different sorts of activities, by less experienced practitioners and pre-registration students. Assessment documents that borrow academic levels criteria or categorise skills and activities in relation to discreet levels (e.g. Level 1, Level 2, Level 3) are highly problematic for assessors who either ignore them and make intuitive judgements or struggle to find evidence to fit the documentation. The research has shown that, given the right conditions, it *is* possible to carry out a systematic and rigorous assessment of practice competence and to differentiate between different perspectives. Because the analogy of levels of competence in practice with academic levels is misleading, there have been difficulties in using practice level as a factor in making awards.

- Practice assessment descriptors should differentiate between levels of practice in terms of broadening perspective on, and increasing capacity to encompass, practice for 'now', 'alternative now' and 'future' practice as parallel processes.
- Practice assessment criteria should be made explicit in terms of the use, in context, of:
  - knowledge
  - skill
  - situated understanding
  - practical theory
  - professional judgement
  - problem-mapping
  - ability to construct rationales for explanation and understanding at strategic and tactical levels of action
  - ability to enact those strategies and tactics.
- Practice assessment transcripts should clearly indicate how this set of criteria has been demonstrated within each of the three perspectives (practice for 'now', 'alternative now' and 'future').
- Academic institutions should decide for themselves whether to adjust the overall academic grade of an award in the light of the professional level descriptor, bearing in mind that it is arrived at systematically and rigorously but through other criteria than traditional academic ones.

9. **Continuing development in the quality of practice assessment will require the supplementation of current clinical and educational audit with a system for monitoring actual provision for education and assessment.**

With the exception of educational audits – which are often cursory and driven by a need to find places, influencing the criteria chosen and causing adjustment downwards of conditions for what is acceptable – there are few systematic structures for monitoring the quality of placement provision for students. There is evidence that trusts make commitments which they either do not implement or are unable to maintain because of a financial agenda. This often means that practice assessment is being undertaken in circumstances which are unfair. Consortia have a role to play in promoting educational curricula in the workplace, at present, this rarely includes monitoring the provision of resources for education and assessment; indeed,

it is often assumed that responsibility for provision of those resources is the educational institution's.

- Every clinical institution should prepare and publish a curriculum for workplace learning and assessment, stating resources and support structures provided, including an outline of the procedures in place for facilitating team assessment.
- Educational audit should examine the procedures a designated area has for matching resources to learning/assessment needs.
- Educational audit should include an evaluation of access to knowledge systems and knowledge flow in clinical environments.
- Light monitoring should be carried out locally on a regular basis and findings co-ordinated at a regional level.
- This light monitoring should be complemented by less frequent evaluations of assessment practice and procedures carried out by approved teams of qualified educational evaluators.

10. **The enormous resource and added value provided to trusts by students/assessees through their contribution to knowledge networking and hands-on practice (even when they are officially supernumerary) needs to be recognised on a *quid pro quo* basis by the allocation of trust monies to learning and assessment support structures.**

Liaison between trusts and educational institutions, often mediated through educational consortia, is usually regular and mutually valued. Nevertheless, educational institution staff often express dissatisfaction with the provision made by some trusts for support of training and doing of assessment in the workplace. The problem is not usually one of deliberate constraint but more a matter of the trust not having prioritised provision for students/assessees. The consequence is that students are often absorbed into the workforce and used as a substitute for qualified staff during absences through sickness or work elsewhere. The resource they provide is not recognised officially because it is rarely a requirement leading to something being recorded, but rather an implied obligation 'just to help out'. There was evidence to suggest that without student contributions, many trusts would be severely under-staffed at times of crisis.

- Workloads carried by both pre- and post-registration students, whether supernumerary or not, should be recognised as an essential resource and monies allocated on a *quid pro quo* basis in trust budgets to support education and assessment in the workplace.
- As a member of a clinical team a student should carry a caseload but should be entitled to staged entry into this, preferably on the basis of curricular need.



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# RESEARCHING PROFESSIONAL EDUCATION

*A series from the English National Board for Nursing, Midwifery and Health Visiting*

## Practice and Assessment in Nursing and Midwifery: doing it for real

**Terry Phillips**
**John Schostak**
**Judith Tyler**

This report, in the Board's series *Researching Professional Education*, has been published to make Board-commissioned research readily available to policy makers, practitioners, researchers and educationalists.

The quality of assessment of practice varies widely. *Practice and Assessment in Nursing and Midwifery: doing it for real* investigates how practice is assessed in clinical environments. It looks at the interaction between what assessors 'do', the way organisations are structured and how resources are distributed. The researchers observed learners and assessors at work to build up a set of case studies of the working day. At the same time they collected evidence of the reality of assessment in these circumstances.

The research shows that the quality of assessment and learning require the support of appropriate institutional and national infrastructures.

The conclusions are of relevance to a wide multiprofessional audience in health care and education.

**English National Board for Nursing, Midwifery and Health Visiting**
Victory House, 170 Tottenham Court Road, London W1T 7HA
Telephone: 020 7388 3131 Fax: 020 7383 4031
E-mail: link@enb.org.uk Internet: http://www.enb.org.uk

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JULY 2000

# research HIGHLIGHTS

# Practice and Assessment:

## An evaluation of the assessment of practice at diploma, degree and postgraduate level in pre- and post-registration nursing and midwifery education

**Research Team Members:**

*Core Research Team*

Dr Terry Phillips, Co-Director, University of East Anglia

Prof John Schostak, Co-Director, University of East Anglia

Dr Judith Tyler, Senior Research Associate (June '98 - January 2000), University of East Anglia

Libby Allen, Project Secretary (August '98 - January 2000), University of East Anglia

*Previous Team Members*

Kay Woroch, Senior Research Associate (April '97 - March '98)

Sarah Collen, Research Associate (April '97 - December '97)

Cathy Borwick, Project Secretary (April '97 - July '98)

*Part-Time Research Associates*

Gordon Blades (January '98 - April '98)

Sally Hardy (January '98 - April '98)

Dr Katherine Kite (January '98 - April '98)

Bruce Lindsay (January '98 - April '98)

**Steering Group Members:**

Professor Colin Blott (Chair), University of Northumbria at Newcastle

Dr Sonia Crow, Assistant Director (R&D), English National Board

Dr Kate Gerrish, Sheffield Hallam University

Richard Hogston, Department of Health

John Leung, Education Officer, English National Board

Professor Lesley Page, Professor of Midwifery, Thames Valley University

Azad Ramkolees, Education Officer, English National Board

Dr Harry Torrence, University of Sussex

**English National Board for Nursing, Midwifery and Health Visiting**

Victory House
170 Tottenham Court Road
London W1T 7HA

Telephone: 020 7388 3131
Fax: 020 7383 4031

## Abstract

**The research investigated how practice is assessed in clinical environments. It looked at the interaction between what assessors 'do', the way organisations are structured and how resources are distributed. The researchers observed learners and assessors at work to build up a set of case studies of the working day. At the same time they collected evidence of the 'reality' of doing assessment in these circumstances. The Research Highlights give a picture of many practitioners so hard-pressed by the demands of day-to-day nursing and midwifery that they are regularly unable to undertake valid or reliable assessment. They clearly indicate that quality assessment and learning require the support of appropriate institutional and national infrastructures. The research findings are of relevance to a wide multi-professional audience in health care and education.**



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# Main Findings

The evaluation of practice assessment for pre-registration and post-registration awards identified 10 key findings:

1. The quality of assessment varies enormously. Its nature and effectiveness often depend on accidental circumstances such as the level of staffing in a clinical area and the shape of a working day. Because there is rarely a planned curriculum for practice learning and assessment, these activities cannot easily take place without compromising patient care. To overcome this, many individual assessors invest a great deal of their own time and effort to help their assessees[1]. They do this at a cost to themselves in terms of stress and personal well-being. For a large number of others, however, assessment is just one more piece of bureaucracy that takes away from time to do the job. It is the straw that breaks the camel's back.

2. Official, named practitioner-assessors are having to perform their assessor role as one of many roles. For most of them, the first priority is getting through the working day, the second is giving quality patient care and the third, undertaking assessment. The working day is full of interruptions. They are often called away from one clinical task to begin another, to answer the telephone, to comfort a relative, to provide information for another professional. There is rarely much continuity of contact between them and their assessee. Workloads and shift patterns may prevent them from observing an assessee, having a conversation with them or even meeting them for several days at a time. Few organisations have found a way to overcome the conflicts between care delivery and assessment. For most of them, assessment is a bolt-on activity to be done after *'the things that really matter'*.

3. The majority of assessment is done informally by the people an assessee 'bumps into' as they do their practice. Each person may perceive the assessee differently. Often they will have seen him or her in different circumstances from the ones their colleagues witnessed. In most cases, there is little time set aside for sustained observation of assessees or for systematic evidence collection and dialogue between assessors. Many informal assessors still lack training in assessment. Patterns of work, absence of an infrastructure for assessor dialogue based on evidence and inadequate training combine to minimise inter-assessor reliability. These problems diminish in relation to the amount of overall time the assessee remains with a group of colleagues in one clinical area. Three/four week placements do not permit valid and reliable assessment.

4. The assessment of theory in practice remains a problem for assessors. The assessment of theory is largely an assessment of 'subject' knowledge. This is perceived as something brought to practice and transferred unaltered from one situation to another. Few assessment schedules recognise the theory that *comes from practice*. This is knowledge that is constructed in context (in particular clinical situations, throughout the whole working day) and involves knowledge gained through the fingertips, knowledge about when "to cut corners" and knowledge about how to prioritise

[1] The term 'assessee' is used rather than 'student' because there are a range of people being assessed. Those on pre-registration courses are students first and foremost and practitioners second. Those undertaking a programme of learning for a post-registration award consider themselves practitioners who are 'doing a course'. The word 'assessee' encompasses both.

among apparently equal demands. Many practitioners are confirmed in their scepticism about theory by assessment schedules that use criteria which fail to recognise the 'real' world of practice. Where work is organised to facilitate extended periods of observation and assessors are able to work alongside their assessee, assessment more often uses and openly acknowledges 'real' practice criteria that recognise theory-from-practice.

5. Observations and interviews provide extensive evidence that a major part of nursing and midwifery practice is about solving the operational and ethical dilemmas a nurse or midwife regularly faces. Competent practice is less about performance on separate tasks than about handling the competing and contradictory demands upon an individual's time and attention throughout the whole day. Far from treating dilemmas as abstract problems and employing ready-made solutions, competent practitioners resolve these competing demands by treating each problem as 'situated'. They read and analyse the specific, concrete situation, evaluate the competing demands within it, make a judgement that takes account of the situation and the wider context and take appropriate action. Judgement is always a central feature of competent practice. It is rarely featured prominently in assessment schedules.

6. The most valid assessment of a) situated knowledge and b) judgement occurs where there is opportunity for close observation over a sustained period by an assessor working alongside their assessee. This happens where there is a set of structures that facilitate co-working or team work as a regular part of clinical practice. This form of working enables in-event dialogue, on the one hand, and negotiated action, on the other. It is not a way of doing things which occurs often in the current context of healthcare. In rare instances, assessors are able to withdraw from primary responsibility for other aspects of care while they are doing their period of collaborative working-cum-observation.

7. Nursing and midwifery practice has to meet the expectations of a wide range of stakeholders, including individual patients and relatives, individual practitioners, user groups, Trusts, Higher Education Institutions, Education Consortia, the ENB, the UKCC and the Department of Health. As they work, nurses and midwives have to do things that meet multiple and often contradictory agendas. There is an evident need for a greater degree of regular, constructive dialogue between all interest groups, with a view to developing curricula for learning and assessment that explicitly acknowledge the need for practitioners to juggle competing agendas. The data indicates a parallel need for practitioner-assessors to be involved pro-actively in as many planning and decision-making bodies at as many levels as possible.

8. The evidence shows that the conditions under which people are assessed are infinitely variable and that competence is always 'situated'. It indicates that assessment must meet two conditions if it is to be fair and comparable. First, it must take into account the constraints and possibilities of the clinical environment. Assessees have to analyse the context as a normal part of doing practice, so it seems sensible that assessment should include a joint assessor/assessee review of the context, mapping 'real' practice problems within richly described contextual detail. Second, assessees should be systematically observed in a range of situations, from those that demand a

'usual' response, through those where there is a real possibility of exercising choice, to those where there is a need for strategic action to bring about change in the context of care.

9. The majority of research informants claimed not to be able to detect levels in practice; a competent nurse/midwife was a competent nurse/midwife. Observation indicated that practitioners continue to *broaden the scope* of their competence rather than climb to another level. It also showed they move back and forth between doing practice in routine ways, making choices in unusual situations and making interventions in the context to improve the possibilities of healthcare in the future. Assessment which provides a valid picture of how nurses and midwives actually develop as practitioners moves away from the academic notion of progress as movement through levels and towards: assessment of ability to practice 'now'; in an 'alternative now'; in an unknown future. The latter includes understanding for strategic and tactical action.

10. Few assessors felt well prepared for doing assessment and most expressed a desire for continuing support after initial training. There were few effective structures for preparing, developing and supporting assessors. Meetings for practitioners lacked continuity from one session to another. Little or no attention was given at these meetings to the critical analysis of differences in perceptions, assumptions and values. Examples of assessors meeting to inform their assessment by presenting and analysing evidence of their own practice were rare. Frameworks for assessor training and support seemed to ignore a) the inter-subjective nature of assessment and b) the need for dialogue to enhance the judgement required for appropriate action in the face of uncertainty. There is little evidence of an infrastructure for monitoring the provision of resources or mechanisms to promote education and assessment as integral parts of practice.

## Portfolios and Vignettes

The ACE project in 1994 argued for assessment as a process of dialogue and critique. It proposed the use of portfolios of evidence as a focus for this dialogue. The current evaluation has found that portfolios are a valuable way of collecting together evidence of particular events and fostering private reflection on them. They do not, however, provide access to 'thinking in action'. They are usually constructed after the event, outside the context of action and beyond the context of initial understanding. This means they focus on completed thinking and finished action. Most of them do not provide evidence of a person's competence to practice in environments whose key characteristics are ambiguity and complexity. This can only be done through sustained observation in the practice environment.

The research suggests that portfolio based assessment is most useful outside the practice environment where each portfolio can be assessed as a set of practices in itself. These practices will reveal an assessee's ability to reflect on alternative courses of action, imagine different practice scenarios, identify the values behind practices, appraise contexts, and rehearse strategies for 'the now'.

The research also suggests that if writing is to be useful in developing situated judgement and action, it must capture the lived experience of practice as a series of encounters with dilemma and uncertainty in all its contextual detail. And it must promote dialogue *in the workplace itself*. There appears to be a case for the construction and use of short narrative

accounts as part of the assessment process in the workplace. The research report includes many such narrative accounts - in the form of vignettes - to demonstrate how they can be used to motivate dialogue about particular events and the bigger picture.

# Method

The design for the project grew out of two previous projects, ACE and TYDE[1], and culminated in what may be called *dialogic evaluation*. Dialogic evaluation seeks to identify the range of different voices, experiences, ways of seeing, doing and talking about the world and to bring them into debate in order to explore alternative rationales and enhance the knowledge base by which to inform judgement, decision-making and action.

Dialogic evaluation explores differences through three key interrelated dimensions. Firstly, the conceptual/discursive dimension through which ideas are framed into belief systems and systems of (formal and informal) knowledge. Secondly, the pragmatic dimension of cultural practices, routines, habits, procedures, mechanisms. Thirdly, the dimension of material resources. In this way dialogic evaluation maps the key structures and processes influencing judgement, decision making, action and the events that are produced through interaction.

The project used five related approaches. Qualitative data was collected through in-depth interviewing, close observation and the collection of documentation. Analytic-descriptive forms of representation were used to preserve the range of voices, experiences, actions and events encountered. Emergent theories were developed over time as data was collected. A formative analysis was carried out by exploring data in relation to the emergent theories to determine the limits to generalisation. Emergent theories were tested with individuals, groups, organisations, systems and contexts not yet included in the database.

Because of the sensitivity of the material collected and represented, the project was framed according to ethical principles of procedure that adhere to codes of confidentiality, anonymisation and rights of participation and access. Without such principles and rights, dialogue would fall into the strategic politics of impression management and cover-up.

[1] An Evaluation of the Assessment of Competence in Nursing and Midwifery Education and The Evaluation of Pre-registration Undergraduate Degrees in Nursing and Midwifery Programmes. Both reports are published through the ENB.

## Further information

For copies of the Research Highlights and the Report, please contact:

ENB
Publications Department
Victory House
170 Tottenham Court Road
London W1T 7HA

For further information about the research process, please contact members of the research team at the Centre for Applied Research in Education (CARE) at UEA:

t.phillips@uea.ac.uk
j.schostak@uea.ac.uk
j.tyler@uea.ac.uk

# Project Details

The project was commissioned by the English National Board for Nursing, Midwifery & Health Visiting in 1998. Strategically, the project was designed to gain access and to bring alternatives into dialogue as a basis for understanding, explaining and transforming clinical environments as a focus for professional development and the assessment of practice. Tactically, the project design was organised to ensure both coverage across the country and depth in terms of situated practices. To this end the period of the project – 36 months – was divided into 4 key activities.

***Activity 1 (June 1998 - February 1999)*** was carried out by a highly experienced team of senior researchers able to undertake fieldwork in concentrated time periods, collecting data from clinical settings across the country in order to gain coverage of the range of issues. The key methods of data collection were interview and documentation.

***Activity 2 (March 1999 - November 1999)*** focused on in-depth case studies, carried out in sites selected after consideration of the data from phase 1. This enabled further interviews and the collection of documentary evidence. However, observation of clinical settings was the primary focus. This provided the kind of material necessary for the development of vignettes of practice.

***Activity 3 (July 1999 - November 1999)*** focused on developing vignettes of practice and in particular, developing models of assessment practice and resourcing.

***Activity 4 (July 1999 - November 1999)*** was the final process of writing the Report.

The Final Report published by the ENB in the Researching Professional Education Series will be of interest and use to all those involved in managing professional education at all levels, and those who are developing educational content and assessment strategies for clinical practice. It provides:

- An analysis and a portrayal of the realities of clinical contexts for assessment and learning from the point of view of assessees, assessors, managers
- Insights into developing practice based curricula
- Analyses of assessment processes
- The development and use of portfolios
- The use of vignettes as a way of undertaking professional development and assessment
- Strategies for monitoring assessment processes

# Development of Learning Materials

The Board has commissioned a development project based directly on evidence which emerged from this research. It will be completed in Spring 2001. The learning materials are focused on practice assessors to promote the assessment of learning within practice.

They include activities to be done in practice placements, and will be equally useful to individual practitioner/assessors or teams of colleagues working together. The materials offer audio, video and vignette examples of practice for analysis but are designed to encourage users to develop narrative and reflective accounts of their own for further work that takes full account of their particular situation. The bigger picture is considered alongside these particular examples.

RESEARCH HIGHLIGHTS

Published by
**English National Board for Nursing, Midwifery and Health Visiting**
**July 2000**

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